Renewal 1915(b) Medicaid Managed Care Waiver

STAR+PLUS

Medicaid Managed Care Program

Harris County

Texas Health and Human Services Commission
Don A. Gilbert, Commissioner
Linda Wertz, State Medicaid Director

September 1, 2002 - August 31, 2004

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Note: For your convenience, the special terms and conditions stipulated in your August 18, 2000, letter, are included in this waiver renewal document as follows:

1. *The State will provide the costs associated with 1915(b)(3) services (elimination of the 30-day spell of illness provision, provision of adult well checks, and elimination of the three prescription drugs a month limit) for this renewal period.*

   This information can be found in Section D Cost Effectiveness, page ____.

2. *The State will arrange for an independent assessment of the wavier with respect to access to care, quality of care and cost-effectiveness. The results of this assessment are to be submitted to CMS no later than 3 months prior to the expiration date of this waiver authority*

   This information is in Attachment 1.

3. *The State will submit to CMS, on an annual basis, the number of children participating in the waiver identified in category 1 of the Balanced Budget Act of 1997 (BBA). Identification through either aid code analysis or manual review is acceptable.*

   This information is in Attachment ____.

4. *The State will review complaints and grievances and track those cases involving children in the waiver identified in category 1 of the BBA's definition of special needs children. On an annual basis, the State will report to CMS the number of complaints and grievances for this group and submit an analysis, stratified by group, of type and number of complaints and grievances filed, and their resolution.*

   This information is in Attachment ____ and was compiled by multiple sources, hence the reporting formats are different.

5. The State will submit to CMS, on an annual basis, the number of children identified in category 1 of the BBA's definition of special needs children who voluntarily transfer between Managed Care Organizations (MCO) or transfer from an MCO to Primary Care Case Management (PCCM).

   This information is in Attachment ____.

Section A. General Impact

I. Background

This §1915(b) Medicaid managed care waiver renewal application continues implementation of the STAR+PLUS pilot program in Harris County. STAR+PLUS provides acute and long-term care services to Medicaid-only clients eligible for SSI, and only long-term care services to dually eligible clients eligible for SSI. Two health maintenance organizations (HMOs), Americaid and HMO Blue, are available for clients to choose; children and certain behavioral health clients also have the option of a primary care case management model. Clients in HMOs with chronic or complex conditions, and clients who request one, are assigned a care coordinator who is responsible for coordinating all aspects of the client's care. All Medicaid only clients receive unlimited Medicaid prescriptions instead of the current limit of three per month. Dual eligibles who choose to receive their Medicare services through the Medicare risk product of the company that runs their STAR+PLUS HMO also receive unlimited Medicaid prescriptions, although this option hasn't been available since December 1999.

A local advisory committee comprised of HMOs, providers, consumers, advocates, state staff and other interested parties began meeting in 1997 to provide input on the preparation for and implementation of Medicaid managed care in the Houston area. Areas of improvement as a result of advisory committee input include enrollment materials and client outreach. This committee met monthly through the first year of implementation and now meets quarterly. Three subcommittees – behavioral health, children with special health care needs, and cultural competency – provide additional, specialized input on areas of particular focus.

HealthCare Matters!, a nonprofit managed care training and education project, assisted the State during the pre-implementation phase by holding regular meetings of stakeholders. These meetings created an ongoing opportunity for consumers and advocacy organizations to ask questions about and provide input on Medicaid managed care. In spite of the fact that the grant which funded HealthCare Matters!, has ended, the working relationships among all stakeholders have continued in Houston as evidenced by the level of participation in regular provider and advisory committee meetings.

In order to assist with the transition to managed care, the State and several provider groups organized ongoing meetings between the HMOs and providers. These ongoing meetings include the Harris County Medical Society, residential providers and home care providers. Issues that arose during implementation as well as ongoing issues can be addressed directly via these meetings. HMO authorization periods for long-term care

services were lengthened and claims systems issues were resolved as a result of these meetings.

The State is committed to an ongoing improvement process that includes the HMOs, providers, consumers, advocates and other stakeholders. Because of this commitment, the implementation of Medicaid managed care in Harris County went much more smoothly than it had in previous areas. In addition, strong working relationships were forged among the various stakeholders. STAR+PLUS is well on its way to becoming a model for public-private partnership and stakeholder inclusion. The State believes that STAR+PLUS results in better, and constantly improving, access and quality for clients.

II. General Description of the Waiver Program

Previous Waiver Period

a. _ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. **The State of Texas** requests a waiver under the authority of section 1915(b)(1) of the Social Security Act (the Act). The waiver program will be operated by the Texas Department of Human Services.

b. **Effective Dates:** This waiver renewal is requested for a period of 2 years; effective September 1, 2002 and ending August 31, 2004.

c. **The waiver program is called** STAR+PLUS.

d. **State Contact:** The State contact person for this waiver is Pamela M. Coleman, who can be reached by telephone at 512/438-5067, or fax at 512/438-2845, or e-mail at pamela.coleman@dhs.state.tx.us.

e. **Type of Delivery Systems:** The State will be entering into the following types of contracts with the MCO or PHP. Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1. X **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that

section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

(a) X The contractor is at-risk for inpatient hospital services and any one of the following services:

i. X Outpatient hospital services,
ii. X Rural health clinic (RHC) services,
iii. X Federally qualified health clinic (FQHC) services,
iv. X Other laboratory and X-ray services,
v. X Skilled nursing facility (NF) services,**
vi. X Early periodic screening, diagnosis and treatment (EPSDT) services,
vii. X Family planning services,
viii. X Physician services, and
ix. X Home Health services.

(b) _ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2. _ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be implemented by the State:

(a) _ The contractor is at-risk for inpatient hospital services,
OR
(b) _ The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i. _ Outpatient hospital services,
ii. _ Rural health clinic (RHC) services,
iii. _ Federally qualified health clinic (FQHC) services,
iv. _ Other laboratory and X-ray services,
v. _ Skilled nursing facility (NF) services,
vi. _ Early periodic screening, diagnosis and treatment (EPSDT) services,

vii. _ Family planning services,
viii. _ Physician services, and
ix. _ Home Health services.

3. X **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

The PCCM model in Harris Service area is a managed care delivery system in which the State forms its own network of primary care providers (PCPs) and hospitals and contracts directly with those providers under a restructured delivery system that relies on managed care principles. The PCCM includes the use of a "manager of care" or "medical home" (the PCP) and utilization controls (such as concurrent review) on inpatient hospital services. Under this model of managed care, the primary care providers receive fee-for-service reimbursement plus a monthly case management fee for providing primary care services.

4. _ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

1. X **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollmer

2. X **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

   - *Annual adult well-check: provided to all enrollees 21 and over, this includes health history, physical examination, lab and diagnostic procedures, and counseling on health issues.*
   - *Unlimited prescription drugs: Under traditional Medicaid, clients over 21 who are not in an institution receive only three Medicaid prescriptions each month. STAR+PLUS clients who are Medicaid only, and those dual eligibles who are enrolled in the Medicare risk product of their Medicaid MCO's company, will receive as many prescriptions each month as are medically necessary.*
   - *Unlimited inpatient services: The 30 day spell of illness limitation on inpatient services for clients over 21 will be waived. These clients will receive medically necessary care without a time frame limitation.*

3. X **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. **Sections Waived.** Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1. X **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is n Revised 9/13/2002 throughout the State.

2. X **Section 1902(a)(10)(B)** - Comparability of Services--This Section

of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4. _ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

5. _ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

i. **Geographical Areas of the Waiver Program:** Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1. _ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2. X Other: Harris County only

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

City/County/Region	Name of Entity*	Type of Entity (e.g., PHP, Staff model HMO)
Harris County	Amerigroup	HMO
Harris County	HMO Blue	HMO

*If the State does not yet know the names of the contracting entities, please generalize the number and type expected. The State should submit the entity names and contracts to the Regional Office as part of the contract prior approval process. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1. X This model has a choice of managed care entities.

   (a) X At least one MCO and PCCM

   (b) _ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)

   (c) _ Two or more MCOs

   (d) _ At least one PHP and a combination of the above entities

2. _ This model is an HIO.

3. _ Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

k. Waiver Population Included: The waiver program includes the following

targeted groups of beneficiaries. Check all items that apply:

1. _ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. _ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3. X Blind/Disabled Children and Related Populations (SSI)

4. X Blind/Disabled Adults and Related Populations (SSI)

5. X Aged and Related Populations

6. _ Foster Care Children

7. _ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8. _ Other Population(s) Included - If checked, please describe these populations below.

9. _ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

    i. _ Children with special needs due to physical and/ or mental illnesses,
    ii. _ Older adults,
    iii. _ Foster care children,
    iv. _ Homeless individuals,
    v. _ Individuals with serious and persistent mental illness and/or substance abuse,
    vi. _ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
    vii. _ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
    viii. _ Other (please list):

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. _ have Medicare coverage, except for purposes of Medicaid-only services;

2. _ have medical insurance other than Medicaid;

3. X_ are residing in a nursing facility; **

4. X are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. _ are enrolled in another Medicaid managed care program;

6. _ have an eligibility period that is less than 3 months;

7. _ are in a poverty level eligibility category for pregnant women;

8. _ are American Indian or Alaskan Native;

9. _ participate in a home and community-based waiver;

10. X receive services through the State's Title XXI CHIP program;

11. X have an eligibility period that is only retroactive;

12. X are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

    i. _ Children with special needs due to physical and/ or mental illnesses,
    ii. _ Older adults,
    iii. X Foster care children,
    iv. _ Homeless individuals,
    v. _ Individuals with serious and persistent mental illness and/or substance abuse,
    vi. _ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
    vii. _ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
    viii. _ Other (please list):

13. X have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

- *Clients participating in a 1915(c) waiver other than the State's Community Based Alternatives (CBA) waiver*
- *Clients not eligible for full Medicaid benefits (1929 program, QMB, SLMB, QDWI, undocumented aliens)*

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. X This is the first or second renewal of the waiver. An Independent Assessment is included as **Attachment 1.**

2. _ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. Marketing:

Previous Waiver Period

1. _ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:

2. X [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.

   The State has a set of Marketing Guidelines that MCOs must follow. All marketing materials must be prior approved by the State, thereby ensuring that enrollees receive accurate, unbiased information about their plan and provider choices. This is monitored through the prior approval process and through review of complaints received by the State or Enrollment Broker.

   MCOs are prohibited from providing marketing materials to potential enrollees except at enrollment events that are approved by the State and overseen by the Enrollment Broker.

   The State has not encountered any problem with its marketing requirements during the waiver period.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1 through 7 of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. _ The State does not permit direct or indirect MCO marketing (go to item “b. Enrollment/Disenrollment”)

2. X The State permits indirect MCO marketing (e.g., radio and TV advertising for the MCO in general). Please list types of indirect marketing permitted.

   The State permits MCOs to conduct indirect marketing such as radio and TV advertising for the MCO in general. However, all marketing materials regarding the program or Medicaid in general, including advertising scripts, are prior approved by the State. MCOs are prohibited from targeting certain types of clients with such marketing, and must follow all marketing guidelines set by the State

regardless of the marketing medium. No marketing, either direct or indirect, may be conducted without prior approval by the State.

3. _ The State permits direct MCO marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4. X The State prohibits or limits MCOs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

   All materials, gifts or incentives given to enrollees and potential enrollees must be prior approved by the State. MCOs may give gifts of nominal value ($10 or less) to potential enrollees, However, the gift may not be conditional upon the potential enrollee joining that MCO. All potential enrollees must be given the same gift regardless of their subsequent choice of MCO.

5. X The State permits MCOs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

   The State does not dictate how the MCOs pay their marketing representatives. However, MCO marketing representatives are only allowed direct contact with clients at State-sponsored enrollment events, which are supervised by the Enrollment Broker. An Enrollment Broker employee, and not the MCO marketing representative, enrolls clients who opt to enroll at these events. Because clients may choose to mail or phone in their enrollment later, it would be difficult for the MCOs to isolate which clients may have joined their plan due to the efforts of a particular marketing representative. The State prohibits coercive or fraudulent marketing practices. The State has encountered no problems during the waiver period with coercive or fraudulent marketing practices.

6. X The State requires MCO marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

Spanish

The State has chosen these languages because (check any that apply):

i. _ The languages comprise all prevalent languages in the MCO service area.
ii. X The languages comprise all languages in the MCO service area spoken by approximately **10** percent or more of the population.
iii. _ Other (please explain):

7. X The State requires MCO marketing materials to be translated into alternative formats for those with visual impairments.

8. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a) X Ensures that all marketing materials are prior approved by the State

(b) X Ensures that MCO marketing materials do not contain false or misleading information

(c) X Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials

Marketing materials are shared with the MCAC for review and comment. The State also seeks input on these materials from the regional STAR+PLUS advisory committee, which is comprised of MCO representatives, acute and long-term care providers, advocates, community based organizations and other interested parties. In addition, the statewide advisory committee for Medicaid managed care will also receive the materials for review.

(d) X Ensures that the MCO distributes marketing materials to its entire service area

(e) X Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f) X Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g) X Ensures that MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1. _ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:

2. X [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

- *Any selection or assignment of an MCO may be changed at the request of the client for any reason at any time. An MCO may request to disenroll a client for limited reasons identified in the MCO contract with the State.*

  All requests to change plans are processed by the Enrollment Broker. If the MCO receives an enrollee request to change plans, the MCO is required to immediately refer the enrollee to the Enrollment Broker. The State monitors enrollee right to change MCO at any time through review of complaint reports from the Enrollment Broker and the MCOs. The MCO is allowed to request enrollee disenrollment for limited reasons which are detailed in the contract. Since the State makes all decisions regarding MCO requests for disenrollment, any request not meeting the contractual criteria is denied, and the State explains to the MCO why the request does not meet the criteria. The State encountered no problems with this requirement during the previous waiver period.

- *Clients may disenroll (ie, switch from one health plan to another) for any reason at any time.*

Any client who contacts the Enrollment Broker with a plan change request is changed to the new plan. The State's contract with the Enrollment Broker requires that the change be made as requested. This is monitored through review of quarterly client complaint reports. The State encountered no problems with this requirement during the previous waiver period.

- *Clients may disenroll from an HMO under this mandatory enrollment program because another HMO or another managed care program will be available for re-enrollment.*

  Any client who contacts the Enrollment Broker with a plan change request is changed to the new plan. The State's contract with the Enrollment Broker requires that the change be made as requested. This is monitored through review of quarterly client complaint reports. The State has not encountered any problems with this requirement during the waiver period.

- *Client disenrollment must be effective no later than the beginning of the first calendar month following a full calendar month after the request for disenrollment is made.*

  The State requires the Enrollment Broker to process all enrollee plan change requests received prior to the State's cut-off date (approximately the middle of each month) so that the enrollee can begin receiving services from the new plan on the first of the following month. The State requires that all enrollee plan change requests received after cutoff be processed so that the enrollee can begin receiving services from the new plan on the first of the month following the month after the request is received. The State has not encountered any problems with this requirement during the waiver period.

- *Change of Primary Care Provider for those clients who are defaulted into the PCCM program can be made for cause at any time.*

  A PCCM client request for a PCP change will be effective on the first of the following month of the request is received before the State cutoff date. The request will be effective on the first of the month following the next month if the request is received after

the cutoff date.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. X **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

   The State's Enrollment Broker, Maximus, performs outreach activities, conducts enrollment events, and assists clients with enrollment in person and over the phone. Outreach includes notifying clients about the program through publicized events, partnering with community based organizations to disseminate information about the program, and brochures, flyers and posters in the clients' communities. A newly-eligible client receives an enrollment kit in the mail from Maximus. The enrollment kit contains information about STAR+PLUS, information about each HMO including their provider networks, and instructions for enrolling via mail, over the phone, or at an enrollment event. If the client has questions or needs assistance, he or she can contact Maximus. If necessary, Maximus staff do home visits to help clients understand their choices and the enrollment process. In addition to the training Maximus staff received on the traditional Medicaid population, training on the STAR+PLUS population and their special needs was provided by the state. Maximus contracts with community based organizations and consumer advocacy organizations to provide a critical link between the enrollment broker and the aged and disability community.

2. X **Administration of Enrollment Process**:

   (a) _ State staff conduct the enrollment process.

   (b) X The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of

1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: **MAXIMUS**
ii. Procurement method:
(A). X Competitive
(B). _ Sole source
iii. Please list the functions that the contractor will perform:

Maximus performs outreach activities, including enrollment events and presentations at Texas Department of Human Services offices where clients apply for Medicaid. Maximus also mails enrollment kits to clients who become eligible for managed care, sends enrollment counselors on home visits when necessary, and operates a tollfree line which clients call to enroll in managed care or to ask questions. Maximus processes client enrollments and transmits this information to the MCOs, and tracks enrollment and disenrollment activity as well as size of provider panels.

(c) _ State allows MCOs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a) X Mandatory for populations in Section A.II.K

(b) _ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c) _ Other (please describe):

4. **Enrollment:**

(a) X The State will make counseling regarding their MCO choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential

enrollees.

The Enrollment Broker conducts enrollment events in locations around Harris County that are accessible to clients, such as community centers, Texas Department of Human Services offices, housing projects, shopping centers, and other convenient locations frequented by clients. Enrollment counselors are also available for home visits for clients who are unable to travel to enrollment events because of mobility impairments, blindness, frail health condition, lack of respite care for children while the parent travels to an event, or other disability or health related reason. The Enrollment Broker also operates a tollfree line that clients can call for information or to enroll. Enrollment counselors provide information about how to use a managed care system; the MCO choices available; the PCPs and specialists available in each plan and such information as practice restrictions, languages spoken and whether they are accepting new patients; freedom of choice of Medicare providers; and details of the STAR+PLUS program including care coordination and unlimited prescription drugs. Clients are encouraged to choose an MCO and PCP that meet their personal needs, rather than wait and be auto-assigned to a plan and doctor.

(b) X Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCOs and providers based on their medical needs. Please describe.

Enrollment counselors receive training on managed care, Medicaid, and the MCO options available in the service area. In addition, Harris County enrollment counselors receive additional training specific to the STAR+PLUS population and their unique needs. Enrollment counselors educate clients about all their choices and help them identify the plan or plans in which their desired PCPs and specialists participate. However, the State prohibits the Enrollment Broker from encouraging clients toward specific MCO or PCP choices; the client is to receive all needed information to make a choice, but the choice must be the client's. Because all MCOs are required to meet the medical needs of clients, it is up to each client to determine which MCO is the best "fit" with their needs and preferences.

(c) X Enrollees will notify the State/enrollment broker of their choice of plan by:

i. X mail
ii. X phone
iii. X in person at enrollment events
iv. _ other (please describe):

(d) X [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

The open enrollment period in STAR+PLUS is continuous. Plans must accept any eligible client who chooses their plan.

(e) X Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

Newly eligible clients are mailed an enrollment kit. The kit contains general information about the STAR+PLUS program, including how to choose an MCO and PCP, how long the client has to enroll voluntarily before being auto-assigned, and where to call for assistance with the information or with enrollment. It also contains specific information about each plan and the providers in their networks. In addition, it contains a plan comparison chart that highlights provider network information, lists tollfree numbers for each MCO, specifies which services are provided by all plans, and indicates differences in the value added services offered by each plan. The enrollment kit also includes an enrollment form that can be filled out and mailed in, and a schedule of presentations that clients can attend to get more information about Medicaid managed care and the MCO choices that are available.

(f) _ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g) X If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned

to a plan.

i. Potential enrollees will have 30 days to choose a plan.

ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO that includes their current provider or to an MCO that is capable of serving their particular needs?

STAR+PLUS is specifically designed for special populations and persons with special health care needs. All of the STAR+PLUS MCOs are required to meet the special health care needs of their members. The client chooses their own provider, and is assured that their needs will be met regardless of which MCO they choose.

Newly eligible clients have 30 days after they are mailed an enrollment kit to enroll in STAR+PLUS. The enrollment may be mailed in, phoned in, or done in person at an enrollment event. If a client does not choose a health plan and PCP, if appropriate, within this timeframe, the client is assigned a health plan, and PCP if appropriate. The assignment logic used by the State looks first to see whether any primary care provider has a claims history for the client. If so, the client is assigned to this provider. If not, the logic looks for an available provider within the client's zipcode. If a provider within the zipcode is available, the client is assigned to this provider. If no provider is available within the zipcode, the logic looks for a provider in a surrounding zipcode. Once a provider is assigned, the client is assigned to a health plan with which the provider participates. The health plan assignment is based on the percentage of voluntary enrollments each health plan received.

Clients under 21 and certain behavioral health clients who do not make their own enrollment choices are assigned to the PCCM plan instead of one of the MCOs.

Once a client is enrolled, the client must receive care from that plan and provider unless the client chooses another plan and provider. Clients can change health plans at any time, and can change PCPs at least four times per year. The enrollment broker processes requests for health plan changes. The change is effective on the first of the month following the request so long as the request is received by the State's monthly "cut-off" date – approximately halfway through the month. If the client requests the change past the cut-off date, the change is effective on the first of the next month after the month immediately following the request. PCP change requests are processed by the health plans.

(h) _ The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i) X The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

Clients may request exemption from enrollment in STAR+PLUS through the Enrollment Broker, their health plan, or the State's helpline. The State will honor such a request if it finds that the client's needs cannot be met as well in the STAR+PLUS program as they would be met in fee for service. To make this determination, the State reviews the client's medical condition, which may include contacting the MCO, PCP or other health care providers. State staff discuss with the client, the MCO and providers as appropriate the specific need or needs which the client feels would be better met in fee for service. If the State agrees with the client, the client is removed from managed care and allowed to continue receiving care in the fee for service system.

5. **Disenrollment:**

(a) X The State allows enrollees to disenroll/transfer between MCOs. Please explain the procedures for

disenrollment/transfer:

Clients can change health plans at any time, and can change PCPs at least four times per year. The enrollment broker processes requests for health plan changes. The change is effective on the first of the month following the request so long as the request is received by the State's monthly "cut-off" date – approximately halfway through the month. If the client requests the change past the cut-off date, the change is effective on the first of the month after the month immediately following the request.

(b) _ The State does not allow enrollees to disenroll from the PHP.

(c) X The State monitors and tracks disenrollments and transfers between MCOs. Please describe the tracking and analysis:

The Enrollment Broker produces a monthly report showing the number of clients who changed MCOs for that month. From September 1999 through August 1, 2001, the average monthly number of plan change requests was 397. Average enrollment over the same period was 55,192. Thus, on average, less than one percent (0.72) of the enrolled population requested a plan change each month for this period. The highest number of plan change requests was in August and September 2000, and July and August 2001, when ACCESS STAR+PLUS and ACCESS+PLUS, respectively, phased out and clients were defaulted to a plan if they failed to choose one. The lowest number of plan change requests was 165 (.29 percent) in May 2000.

(d) _ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i. _ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.
ii. _ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP
iii. _ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iv. _ MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e) X The State does not have a lock-in, and enrollees in MCOs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

The State requires the Enrollment Broker to process all client requests for plan changes. The change is effective on the first of the month following the request so long as the request is received by the State's monthly "cut-off" date – approximately halfway through the month. If the client requests the change past the cut-off date, the change is effective on the first of the month after the month immediately following the request.

6. **MCO Disenrollment of Enrollees**: If the State permits MCOs to request disenrollment of enrollees, please check items below which apply:

(a) X The MCO can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO can request reassignment of an enrollee:

An MCO may request that a client be disenrolled from the MCO. The State's contract with the MCO spells out the limited reasons for which an MCO may make such a request:

- *Disruptive behavior at HMO's facility or a network provider's office, unrelated to a physical or behavioral health condition*
- *Loaning or allowing another person to use HMO's membership card*
- *Other circumstances approved by DHS*

Requests for disenrollment may not be based on the client's health status or condition. The State reviews MCO requests

for client disenrollments according to the guidelines in the contract. The State considers the information presented by the MCO, and may contact the client and their provider(s) if appropriate for additional information. The State will either exempt the client from participation in the STAR+PLUS program or will require the MCO to continue serving the client, with suggestions for alleviating the issue that caused the MCO request. The State encountered no problems with this requirement during the previous waiver period.

(b) X The State reviews and approves all MCO-initiated requests for enrollee transfers or disenrollments.

(c) X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO to remove the enrollee from its membership.

(d) X The enrollee remains a member of the MCO until another MCO is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

Previous Waiver Period

1. _ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. X **Required MCO Elements:** MCOs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. X **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a) X The State believes that the requirements of section

1915(b)(4) of the Act are met for the following reasons:

i. X Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii. X MCO must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. X MCO must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv. X Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. X There are no restrictions that discriminate among classes of providers on ground unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs that will operate under the waiver in the following manner:

(a) X The State has used/will use a competitive procurement process. Please describe.

The State conducted a concurrent procurement for the STAR (TANF Related) and STAR+PLUS (SSI Related) Medicaid populations in Harris County. For STAR+PLUS, five HMOs submitted responses to the Request for Application (RFA). There was a review team to review responses from the applicants for STAR and a review team to review the responses for STAR+PLUS. The review team for STAR+PLUS was comprised of representatives from the Texas Department of Health, the Texas Health and Human Services Commission, and the Texas Department of Human Services (including a representative from the Harris county

region).

The technical responses were reviewed and points were awarded based on the responses. The top three scoring responses were recommended for award. Award of the contract was dependent on the responders being successful in receiving an award of a STAR contract.

(b) _ The State has used/will use an open cooperative procurement process in which any qualifying MCO may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c) _ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4. X Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

d. SERVICES

Previous Waiver Period

1. _ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

2. X [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

- *A13: Nonrestricted Services*

  Enrollees may self-refer for nonrestricted services within the MCO's provider network. The State requires that the MCO provide enrollees information about how to access nonrestricted

services in the Member Handbook, which the State reviews and approves. State monitoring involves review of utilization data, as well as review of the plans' quarterly client complaint reports.

- *A14: Emergency Services*

  The State ensures that enrollees in MCOs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. The MCO is contractually required to provide all medically necessary emergency services 24 hours each day, 7 days a week, either by access to physician consultation or emergency medical care, if needed through the HMO's or PCP's own facilities or through arrangements approved by the State with other providers. The State reviews the plans' quarterly client telephone and written complaint reports and utilization management data to determine if access to emergency care and/or after hours access is a problem. State staff, as well as the State's EQRO, randomly contact primary care providers offices during regular and off hours to determine if they are providing appropriate after hours access. Emergency and after hours care is included as a standard for review in the MCO annual external quality improvement audit, which includes review of MCO corporate documents to verify that the contracting plans have stated procedures for emergency and after hours care.

  The State also requires the MCO to provide adequate information to all enrollees regarding emergency service access in its Member Handbook. The State reviews and approves the Member Handbook that MCOs are required to send all new enrollees.

- *A14: Family Planning*

  In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program. The State reviews the plans' quarterly client telephone and written complaint reports and utilization management data to determine if access to family planning services is a problem. Family planning is included as a standard for review in the MCO external quality improvement audit, which includes review of MCO corporate documents to

verify that the contracting plans have stated procedures for family planning services.

The State also requires the MCO to provide adequate information to all enrollees regarding unrestricted access to family planning service in its Member Handbook and Provider Directory. The State reviews and approves the Member Handbook that MCOs are required to send all new enrollees.

- *A21: FQHC Services*

  The State requires the MCOs to make a good faith effort to include FQHCs in their provider networks. Enrollees are required to choose an MCO with an FQHC in its network if they wish to receive FQHC services. The State reviews quarterly client complaint reports to monitor provision of FQHC services.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. X The Medicaid services MCOs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO contract; which non-covered services are impacted by the MCO (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as an example only. States should modify the list to include:

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this

is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO, i.e. not included in the reimbursement paid to the MCO. However, do not include services impacted by the MCO (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO: Check this column if the service is not the responsibility of the MCO, but is impacted by it. For example, if the MCO is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO (see column 5).

The following services apply to Medicaid-only clients:

Service	State Plan Approved	1915(b)(3) waiver services	MCO Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement impacted by MCO
Adult Well Check		X	X		
Ambulance Services	X		X		
Ambulatory Surgical Center Services	X		X		
Birthing Center	X		X		
Certified Nurse Midwife	X		X		

Service	State Plan Approved	1915(b)(3) waiver services	MCO Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement impacted by MCO
Services					
Chemical Dependency Treatment	X		X		
Chiropractic	X		X		
Early Screening, Diagnosis and Treatment of Behavioral Disorders	X		X		
Early Childhood Intervention	X		X		
Emergency Services	X		X		
EPSDT	X		X		
EPSDT Case Management	X			X	
EPSDT Dental	X			X	
Family Planning Services	X		X		
Federally Qualified Health Center Services	X		X		
Genetics	X		X		
Hearing Aid Services	X		X		
Home Health	X		X		
Hospice	X			X	
Inpatient Hospital – All Care	X		X		
Inpatient Hospital – Mental Health and Chemical Dependency Treatment	X		X		
Inpatient Hospital - Psych	X		X		
Lab and x-ray	X		X		
Licensed Master Social Workers – Advanced Clinical Practitioners	X		X		
Licensed Professional Counselors	X		X		
Maternity Clinic	X		X		
Occupational therapy	X		X		
Outpatient Hospital	X		X		
Pharmacy	X	X			X
Physical Therapy	X		X		

Service	State Plan Approved	1915(b)(3) waiver services	MCO Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement impacted by MCO
Physician	X		X		
Podatric	X		X		
Pregnant Women and Infants Case Management	X			X	
Professional Services	X		X		
Psychiatry	X		X		
Psychologist	X		X		
Rehabilitation Services (MH)	X			X	
Renal Dialysis	X		X		
Rural Health Clinic	X		N/A*		
School Health and Related Services	X			X	
Speech/Language Therapy	X		X		
Targeted Case Management	X			X	
Total Parenteral Hyperalimentation	X		X		
Triage Fees	X		X		
Transplant Services	X		X		
Transportation - Non-emergency	X			X	
Tuberculosis Clinic Services	X			X	
Vision Exams and Glasses	X		X		
Value added services			X		
Day Activity and Health Services	X		X		
In home Respiratory Care Services	X		X		
Nursing Facility Care	X		X		
Personal Assistance Services	X		X		
1915(c) (CBA) Adaptive aids	X		X		
1915(c) (CBA) Adult Foster Homes	X		X		
1915(c) (CBA) Assisted living/Residential Care	X		X		
1915(c) (CBA) Emergency response services	X		X		
1915(c) (CBA) Medical Supplies	X		X		

Service	State Plan Approved	1915(b)(3) waiver services	MCO Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement impacted by MCO
1915(c) (CBA) Nursing Services	X		X		
1915(c) (CBA) Occupational Therapy	X		X		
1915(c) (CBA) Personal Assistance Services	X		X		
1915(c) (CBA) Physical Therapy	X		X		
1915(c) (CBA) Respite Care	X		X		
1915(c) (CBA) Speech Language Therapy	X		X		
Unlimited Hospital Stay		X			

* There are not any Rural Health Clinics in Harris County.
** The nursing home population was removed from STAR+PLUS during the previous waiver period. This policy change requires the STAR+PLUS MCOs to pay for 120 days (4 months) of nursing facility services for STAR+PLUS members moving into nursing facilities from community services.

2. X **Emergency Services (Required)**. The State must ensure enrollees in MCOs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity.

   For MCOs, “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

   (a) _ The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

   The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

   (b) X The State ensures enrollee access to emergency services by requiring the MCO to provide adequate information to all enrollees regarding emergency service access (see Section

H. Enrollee Information and Rights)

(c) X The State ensures enrollee access to emergency services by including in the contract requirements for MCOs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.

i. X For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii. X The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii. X Both the screening/evaluation and stabilization services when a clinical emergency is determined,

iv. X Continued emergency services until the enrollee can be safely discharged or transferred,

v. X Post-stabilization services which are pre-authorized by the MCO, or were not pre-authorized, but the MCO failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO contacts the emergency room and takes responsibility for the enrollee.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

(a) X Enrollees are informed that family planning services will not be restricted under the waiver.

(b) X Non-network family planning services are reimbursed in the following manner:

i. X The MCO will be required to reimburse non-network family planning services

ii. _ The MCO will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii. _ The State will pay for all family planning services, whether provided by network or non-network providers

iv. _ The State pays for non-network services and capitated rates were set accordingly.

v. _ Other (please explain):

(c) _ Family planning services are not included under the waiver.

4. X **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

- *Behavioral health services: Enrollees may self refer to any provider within the network*
- *Family planning services: Enrollees may self refer to any provider.*
- *HIV diagnosis services: Enrollees may self refer to any provider within network.*

5. X **Monitoring Self-Referral Services**. The State places the following requirements on the MCO to track, coordinate, and monitor services to which an enrollee can self-refer:

The HMOs are contractually required to ensure that enrollees receive proper information regarding non-restricted services. The contract also requires the HMOs to have in place a system to ensure coordinated patient care, including an education process that informs enrollees how to obtain all medically necessary care.

The HMOs develop, implement, and monitor standards, policies and procedures for non-restricted services per quality standards outlined in the contract. In addition, the HMOs must report encounter data on non-restricted services in accordance with contract guidelines.

6. X **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

   (a) _ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO to the enrollee during the enrollment period.

   (b) X The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

   Please explain how the State will guarantee all enrollees will have a choice of at least one MCO with a participating FQHC:

   The State requires MCOs to make a good faith effort to contract with FQHCs. The State monitors the contract status of network FQHCs to ensure that at least one MCO has at least one participating FQHC. The HMO makes payments to the FQHC if the client chooses to use FQHC. Payments to FQHC are not made through the FFS system for MCO members.

   (c) _ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) X The State requires MCOs to report EPSDT data, including behavioral health data. Please describe the type and frequency of data required by the State.

The State requires the MCOs to submit quarterly utilization management reports and encounters that include information on EPSDT, showing, by age category, the following:

- *Number of eligible member months*
- *Number of members using EPSDT*
- *Number of EPSDT visits*
- *Number of EPSDT visits per 1000 eligible member months*
- *Number of members with an exception to the periodicity schedule*
- *Number of members with a well-child visit*
- *Number of well-child visits*

*See **Attachment 2** for an example of the SFY 2000-SFY2001 utilization management reports required by the State.*

(b) X EPSDT screens are covered under this waiver. Please list the State's EPSDT screening rates, including behavioral components, for previous waiver period. Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

*Comparison of rates and discussion of SFY 2000 - SFY 2001 are included in **Attachment 3**.*

The State's contract with the MCOs requires the MCO to develop methods to ensure that children under the age of 21 receive THSteps services when due and according to the recommendations established by the American Academy of Pediatrics and the THSteps periodicity schedule for children. The contract requires the MCO to have mechanisms in place to ensure that all newly enrolled members receive an EPSDT checkup within 90 days from enrollment, if one is due according to the American Academy of Pediatrics periodicity schedule, or if there is uncertainty regarding whether one is

due. The MCO must educate and inform members about the services available and how to access them, and must provide education and training to providers. In addition, the MCO must provide an outreach unit that works with members to ensure they receive prompt services and are effectively informed about available EPSDT services. Each month the MCO must retrieve from the Enrollment Broker a list of members who are due and overdue for EPSDT services. Using these lists, the MCO must contact members and encourage those who are periodically due or overdue an EPSDT service to obtain the service as soon as possible. The outreach staff must coordinate with Texas Department of Health outreach staff to ensure that members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

(c) X Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

Rates and discussion of immunization are included in ***Attachment 4****.*

TDH has an active program to encourage Plan participation in the Vaccines for Children campaign. The State is working with the Plans to ensure that there is a focus on working with the respective providers on immunization compliance. There are policy standards for Plans to require providers to maintain immunization status records on patients and actively work to get children immunized. THSteps at TDH has worked to promote the immunization registry to document complete vaccine histories and to *recall and reminder systems at the clinic leve[illegible] also increased provider education regarding vaccines.*

(d) X Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

EPSDT providers are required to administer immunizations according to the periodicity schedule in order to participate in EPSDT. Providers who choose not to participate in the Vaccines for Children Program purchase their own vaccine and may still charge their administrative fee but are prohibited from charging the state for the cost of the vaccine.

(e) X Mechanisms are in place to coordinate school services with those provided by the MCO.

The State's contract with the MCOs requires the MCOs to coordinate, to the extent possible, all services received outside the MCO with those received from the MCO's provider network. During the readiness review conducted prior to implementation, the State looked at relationships the MCOs had developed or had begun developing with entities and groups outside the MCO such as schools, providers of non-Medicaid services that STAR+PLUS clients might access, and community social service organizations.

Section B. Access and Capacity

I. Access Standards

Previous Waiver Period

a. _ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. X **Availability Standards**: The State has established maximum distance and travel time requirements, given clients normal means of transportation, for MCO enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

1. X PCPs

The State's contract with the MCO requires that PCPs be available throughout the service area to ensure that no enrollee must travel more than 30 miles or 45 minutes, whichever is less. MCOs were required, prior to implementation of the program, to provide geographic maps showing their providers' locations. The State reviewed these maps to ensure compliance with the access standard. MCOs must report changes to their provider networks on an ongoing basis so that the State can determine whether changes in the geographic distribution of providers affect the access standard. The State also reviews client complaints and includes questions on the consumer survey to determine whether access to PCPs is a problem.

2. X Specialists

The State's contract with the MCO requires that referral specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and single service health care physicians, dentists or providers be available to ensure that no enrollee must travel more than 75 miles to contact the provider. MCOs must report changes to their provider networks on an ongoing basis so that the State can determine whether changes affect the access standard. The State

also reviews client complaints and includes questions on the consumer survey to determine whether access to specialists is a problem.

3. _ Ancillary providers

4. _ Pharmacies

5. _ Hospitals

6. _ Mental Health

7. _ Substance Abuse Treatment Providers

8. _ Dental

9. _ Other providers

10. X Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

    MCOs submit a provider network termination report on a monthly basis so that the State can determine whether changes affect the access standards. The State reviews quarterly client complaint reports from the MCOs and includes questions in its annual client satisfaction survey to determine whether clients are having problems accessing providers. In addition, the State's EQRO reviews access standards during the annual MCO onsite review.

    Enforcement and sanctions for failure to comply with access standards may include any of the following:

    - *Education and informal mailings*
    - *Telephone and/or mail queries and follow-up*
    - *Request PCP response to identified problems*
    - *Warning letters*
    - *Referral for further investigation*
    - *Referral to State's medical staff for investigation*
    - *Corrective action plans and follow-up*
    - *Change recipient's PCP*
    - *Restriction on types of recipients*
    - *Further limits on the number of assignments*
    - *Ban on new assignments*

- *Transfer of some or all assignments to a different PCP*
- *Suspension or termination as a PCP*
- *Suspension or termination as a Medicaid provider*

11. X Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

The State did not monitor distance or travel times under the fee for service program. The standards chosen by the State were based on estimates of reasonable distances and travel times for accessing care in this service area. The State monitors as discussed in the previous item to ensure that distance and travel times do not exceed the standards that have been set.

12.X Please explain how the MCOs will be required to enable enrollees to access providers.

MCOs are required to provide each new enrollee with a Member Handbook and provider directory, which is reviewed and approved by the State. The Member Handbook includes information on how to access providers and the provider directory lists current contracted providers. MCOs send each enrollee a Member Identification card each month that shows the PCP name and phone number so that enrollees know the appropriate number to call to schedule appointments and access PCP assistance. MCOs are also required to operate a tollfree phone line that enrollees can call with questions or complaints. Phone line staff are trained to educate enrollees how to access providers, including providing information about the Medical Transportation Program, which is operated outside of managed care, and other community resources for transportation to providers. Care coordinators are available to assist enrollees with scheduling appointments, obtaining referrals, and choosing ancillary providers.

b. X **Appointment Scheduling** (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1. X PCPs

Appointments for physical/wellness exams for adults must be scheduled within 10 weeks of the request; appointments for routine care must be scheduled within 2 weeks of the request, and appointments for urgent care must be scheduled within 24 hours of the request.

2. _ Specialists

3. _ Ancillary providers

4. _ Pharmacies

5. _ Hospitals

6. _ Mental Health

7. _ Substance Abuse Treatment Providers

8. _ Dental

9. _ Other providers

10. X Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

    The State's contract with the MCO includes requirements that appointments for physical/wellness exams for adults must be scheduled within 10 weeks of the request; appointments for routine care must be scheduled within 2 weeks of the request, and appointments for urgent care must be scheduled within 24 hours of the request. These requirements are initially reviewed during readiness review of each MCO's Quality Improvement Plan (QIP), which must contain standards for availability and accessibility. Any changes to the QIP must be submitted to the State for approval. The State's contract with the MCO also requires the MCO to have a system to ensure coordinated patient care that must include mechanisms for follow up on broken or missed appointments and to ensure that follow up services are available after emergency care is provided. The MCO contract requires that post-hospital appointments be scheduled prior to discharge and occur no later than seven days following discharge. These systems are also reviewed during readiness review.

    Ongoing monitoring includes review of quarterly complaint logs and

through the annual client satisfaction survey. The State also reviews provider network change reports to determine if changes to the MCO provider network might affect appointment scheduling standards. In addition, the State's EQRO looks at all access standards during the annual MCO onsite review. The State requests corrective action plans if necessary and monitors improvement based on the corrective action plan.

11. X Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

    The State did not monitor appointment scheduling times in the fee for service program. The standards chosen by the State were based on estimates of reasonable appointment scheduling times for this service area. The State monitors as discussed in the previous item to ensure that appointment scheduling times do not exceed the standards that have been set.

c. _ In-Office Waiting Times: The State has established standards for in-office waiting times for MCO enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

The State does not establish standards for in-office waiting times. Instead, the State requires the use of QARI standards, which include requirements for MCOs to develop, implement and maintain a procedure to monitor waiting times for various types of appointments (urgent care, routine care, etc). The State monitors compliance with QARI standards through the annual MCO onsite review conducted by the EQRO.

1. _ PCPs
2. _ Specialists
3. _ Ancillary providers
4. _ Pharmacies
5. _ Hospitals
6. _ Mental Health
7. _ Substance Abuse Treatment Providers

8. _ Dental

9. _ Other providers

10. _ Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.

11. _ Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

II. Access and Availability Monitoring: Enrollee access to care will be monitored as part of each MCO's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Previous Waiver Period

a. _ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint].

- *Clients may choose any of the participating plans in the waiver area as his/her managed care plan. In addition, as per 42 CFR 434.29, within a plan, each Medicaid enrollee has a choice of health professional to the extent possible and feasible.*

  The State requires MCOs to refer enrollees requesting a plan change to the Enrollment Broker. This is monitored through review of complaint reports submitted by the Enrollment Broker and the plans. The State also requires MCOs to permit enrollees to change PCPs and to make their own choice of other health professionals to the extent possible within the MCO's network. This is also monitored through review of complaint reports, as well as through the annual client satisfaction survey, which includes questions about the client choosing their own providers. The State conducted onsite reviews, in 1999 and 2000, of the MCOs since the last waiver period; As part of the reviews, the State interviewed care coordinators. One focus of the interview was client choice of providers, and the State determined that care

coordinators are aware of the importance of client choice and are encouraging clients to choose their own providers.

The MCOs have been especially accommodating of members who want a PCP who is out of network. MCO provider relations staff contact these PCPs and attempt to contract with them, in some cases contracting with PCPs who desire a closed patient panel of only one or two of the MCO's members.

- *The same range and amount of services that are available under the non-wavered Medicaid program are available for waiver enrollees.*

  The State monitors services through utilization data, client complaint reports, and grievance and appeal tracking. MCOs are providing covered services to clients for whom the services are medically necessary.

- *Distances and travel time to obtain services for clients under the waiver will not substantially change from that of the non-waivered Medicaid program.*

  MCO access requirements were based on estimates of reasonable distances and travel times for the service area. The State monitors this through review of provider networks and changes to the networks, and client complaint reports. In addition, as part of the MCO Onsite Review, the EQRO looks at the requirement that MCOs have PCPs available throughout the service area to ensure that no member must travel more than 30 miles, or 45 minutes, whichever is less, to access the PCP.

- The number of providers to participate under the waiver compared to before the waiver is expected to remain the same or increase.

  The State requires each MCO to have sufficient provider capacity to serve at least 45 percent of the mandatory STAR+PLUS eligibles in the service area. The MCO is required to increase network capacity as necessary to accommodate enrollment growth beyond the 45th percentile. During readiness review, provider capacity is determined using the assumption that each provider serves no more than 1500 members. The Enrollment Broker tracks the number of enrollees assigned to each PCP, and notifies the State if any PCP reaches 1200 enrollees. Very few PCPs reach the 1200 level. The State retains the right to determine whether access or quality of care is compromised by a PCP having too large a panel of enrollees. The chart below shows

STAR+PLUS overall provider capacity as of August 2001 (assuming total overlap among plans in PCPs and not including any specialists serving as PCPs):

Provider Count As Of August 31, 2001:

Number of PCPs	*Maximum capacity assumption*	*Total capacity*	*Number of clients*	*Excess capacity*
683	*1500*	*1,024,500*	*56,405*	*968,095*

The following chart shows provider capacity by plan as of August 31*,* 2001 (*not accounting for overlap among plans in PCPs and not including any specialist serving as PCPs).*

MCO	*Number of PCPs*	*Plan capacity*	*45% of eligibles*	*Total enrollment*
Access	715	1,072,500	25,382	3,661
Americaid	531	796,500	25,382	18,435
HMO Blue	437	655,500	25,382	26,445

- *Case management, primary care, and health education are provided to enrollees by a chosen or assigned plan.*

  MCOs are required to provide care coordination to all clients with chronic or complex conditions and to those clients who request it. The State monitors this through quarterly review of client complaint reports, care coordination reports, and the annual care coordination study conducted by the EQRO. In addition, the State conducted an onsite review of the MCOs during 1998 and 1999, which included a limited review of care coordination. A separate care coordination review was completed in 1999 by the EQRO which matched the client needs, identified by care coordinators, with corresponding service authorizations. The study found that service needs were positively associated with service authorizations and interventions. For members with mobility and transfer needs, the findings were more significant, showing that interventions occurred for all members with mobility impairments.

  Primary care is one of the basic expectations of a managed care program; the MCOs are required to provide primary care to all clients. This is monitored through quarterly review of utilization data and client complaint reports, and the EQRO's annual onsite review of the MCOs.

MCOs are providing primary care to clients. The annual consumer satisfaction report is a large portion of evaluating how members are accessing primary care services and the quality of these services. In addition, spot checks done at the plan level and the provider level at random also assist in evaluating the PCP effectiveness at various levels. At the MCO level provider profiles are produced at least every two years in which complaints, satisfaction results, and utilization results are reported as part of the recredentialing process.

Each MCO is required to develop and implement a health education plan. This plan must be reviewed and approved by the State before it is implemented by the MCO. All health education activities and materials must also be prior approved by the State. MCOs are providing health education to members, focusing on diagnoses or conditions that are prevalent in their member populations. The areas that the STAR+PLUS MCOs targeted are:

- → *HIV and AIDS*
- → *Access to behavioral health services*
- → *Care and treatment available for members with disabilities or chronic complex conditions*
- → *Wellness promotion programs*
- → *Advance directives*
- → *Access to emergency care and introduction to managed care*
- → *CHF*
- → *Diabetes*
- → *Asthma*
- → *Sickle cell*

Mechanisims that the MCOs use to educate their members include:

- → *Community health and health education classes*
- → *Support groups*
- → *Member education materials*
- → *One on one education*
- → *Member and provider newsletters*
- → *Focus groups*
- → *Staff development*
- → *Health fairs and educational seminars*
- → *Member advocacy groups*

- *Preauthorization is precluded for emergency and family planning services under the waiver.*

This is monitored through quarterly review of utilization data and client complaint reports, and the EQRO's annual onsite review which includes review of MCO policies and procedures for emergency and family planning services. In addition, the State and MCOs meet regularly with the Texas Hospital Association (THA) to discuss any issues or problems with hospital and emergency room procedures of the MCOs, and representatives of the THA as well as the local medical societies are included on the State's Medicaid managed care advisory committees so that any issues are raised and dealt with quickly. The State encountered no problems with preauthorizations for emergency or family planning services during the previous waiver period.

- *Clients have the right to change plans if the arrangement is not satisfactory.*

  This is monitored through quarterly review of client complaint reports to the MCOs and the Enrollment Broker. In addition, the State receives a special report that reflects client reasons for changing plans. Clients are able to change plans at any time, for any reason.

- *Plans are required to provide or arrange for coverage 24 hours a day, 7 days a week.*

  This is monitored through "spot checks" as well as the annual onsite review conducted by the EQRO. It is also monitored through quarterly review of client complaint reports and utilization management reports. The State encountered no problems with this issue during the previous waiver period.

- *The same grievance system which was in effect under the regular Medicaid program will be in effect under the waiver program. Clients have available a formal appeals process under 42 CFR Part 431, Subpart E.*

  The MCOs are required to notify clients of their rights to the State Medicaid fair hearing process any time a service is reduced, denied or terminated. This process is available to clients whether or not they choose to access the internal MCO procedures. This is monitored through review and approval of MCO notification letters, client complaint reports, and review of client requests to access the State Medicaid fair hearing process. In addition, STAR+PLUS staff receive copies of all fair hearing reports in order to monitor the volume and type of fair hearings.

Upcoming Waiver Period -- For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

a. X Measurement of access to services during and after a MCO's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

b. X Determination of enrollee knowledge on the use of managed care programs

c. X Ensures that services are provided in a culturally competent manner to all enrollees.

d. X Review of access to emergency or family planning services without prior authorization

e. X Review of denials of referral requests

f. X Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g. X Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

h. X Measurement of enrollee requests for disenrollment from a MCO due to access issues

i. X Tracking of complaints/grievances concerning access issues

j. _ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k. _ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. X During monitoring, the State will look for the following indications of access problems.

1. X Long waiting periods to obtain services from a PCP.
2. X Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3. _ Confusion about how to obtain services not covered under the waiver.
4. X Lack of access to services after PCP's regular office hours.
5. _ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6. X Lack of access to emergency or family planning services.
7. _ Frequent recipient requests to change a specific PCP.
8. X Other indications (please describe): *The State also monitors plan changes.*

m. _ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. _ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o. _ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a. _ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:

b. X [Required] MCO Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring.

The State requires each MCO to have providers in sufficient numbers to serve 45% of the mandatory STAR+PLUS eligibles in the service area. During readiness review, the State assumed that no provider serves more than 1500 members in order to determine the 45% threshhold. The MCOs submit monthly provider network termination reports so that the State can determine whether the network changes affect the plan's capacity. In addition, the Enrollment Broker tracks PCP panel size across all MCOs with which the provider has contracted. If the Enrollment Broker notifies the State that a provider has reached 1200 patients, the State begins closely monitoring that provider's future enrollment levels. Monitoring of

higher-volume PCPs is conducted to ensure access to care and compliance with quality standards. The State contacts the MCO or MCOs with which the provider has contracted to notify the MCO of the enrollment level and to determine whether the MCO has any record of access problems with the provider. A provider may be restricted from additional enrollments, or some of the provider's patients may be disenrolled.

The State also monitors to ensure adequate providers through review of quarterly complaint reports from the MCOs and STARline, the annual member and provider satisfaction surveys conducted by the State's EQRO, which include questions about enrollees' ability to access care.

Through all modes of monitoring, the State has not noted any deficiencies in provider capacity. Monitoring of higher volume PCPs did not reveal noncompliance in access to care or with quality standards. The annual member and provider satisfaction surveys conducted by the State's EQRO, which includes questions about enrollees ability to access care did not indicate any issues. In order to follow up on member complaints, the State requested updated geographic mapping of the provider networks from each Plan. After analysis, the State found that the HMOs are meeting the minimum geographic distribution requirement established.

c. _ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two year period.

a. MCO Capacity Standards Revised 9/13/2002

1. _ The State has set enrollment limits for the MCOs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2. X The State monitors to ensure that there are adequate open panels within the MCO. Please describe how often and how the monitoring takes place.

The State monitors the number of providers in the MCO network and PCP panel size. The number of providers is reviewed during readiness review to ensure that the MCO network meets access standards for distance and travel time. The State also receives provider network termination reports on a monthly basis in order to determine whether the number of providers has changed. In addition, the Enrollment Broker tracks PCP panel size across all MCOs with which the provider has contracted. If the Enrollment Broker notifies the State that a provider has reached 1200 patients, the State begins closely monitoring that provider's future enrollment levels. Monitoring of higher-volume PCPs is conducted to ensure access to care and compliance with quality standards. The State contacts the MCO or MCOs with which the provider has contracted to notify the MCO of the enrollment level and to determine whether the MCO has any record of access problems with the provider. A provider may be restricted from additional enrollments, or some of the provider's patients may be disenrolled.

The State also monitors to ensure adequate providers through review of quarterly complaint reports from the MCOs and STARline, the annual member and provider satisfaction surveys conducted by the State's EQRO, which includes questions about enrollees' ability to access care.

3. X [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

The contract contains requirements for network adequacy. MCOs are required to submit provider network termination reports. The State reviews these reports to ensure that the MCO maintains a network sufficient to meet capacity standards specified in the contract. In addition, the Enrollment Broker tracks PCP panel size across all MCOs with which the provider has contracted. If the Enrollment Broker notifies the State that a provider has reached 1200 patients, the State begins closely monitoring that provider's future enrollment levels. Monitoring of higher-volume PCPs is conducted to ensure access to care and compliance with quality standards. The State contacts the MCO or MCOs with which the provider has contracted to notify the MCO of the enrollment level and to determine whether the MCO has any record of access problems with the provider. A provider may be restricted from

additional enrollments, or some of the provider's patients may be disenrolled.

The State also monitors to ensure adequate providers through review of quarterly complaint reports from the MCOs and STARline, the annual member and provider satisfaction surveys conducted by the State's EQRO, which include questions about enrollees' ability to access care.

4. X [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area,** i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program.

For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
FQHCs	5	Americaid: 2 Blue: 0	Same
Hospitals	43	Americaid: 28 Blue:16	Same
Pharmacies	N/A	N/A	N/A
Primary Care Providers (Please specify) - Family Practice - Internal Medicine - OB/GYNs - Pediatricians		Americaid: 744 Specialist: See Attachment 15 Blue: 455 PCP Specialist: See Attachment 15	Same
Adult Day Care	23	Americaid: 29 Blue: 36	Same
CBA Waiver	49	Americaid: 37 Blue: 69	Same

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Primary Home Care	51	Americaid: 77 Blue: 108	Same
Nursing Facilities	56	Americaid: 21 Blue: 60	Same

Some STAR+PLUS HMOs PCPs are also medical specialists. The numbers of each specialty type serving as a PCP is detailed in attachment 15.

Revised 9/13/2002

*Please note any limitations to the data in the chart above here:

For other risk programs, please modify for your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Developmental Disabilities Providers (please specify)	N/A		
Hospitals			

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Mental Health Providers (please specify)			
Pharmacies			
Substance Abuse Treatment & Rehab Providers (please specify)			
Transportation Providers (please specify)			
Vision Providers			
Other (please specify)			

*Please note any limitations to the data in the chart above here:

b. PCP Capacity Standards

1. X The State has set capacity standards for PCPs within the MCOs expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

   i. _ PCP to enrollee ratio

   ii. _ Maximum PCP capacity

   iii. X For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans

   The Enrollment Broker tracks PCP capacity across plans and notifies the State whenever a PCP reaches 1200 patients. The State does not generally limit PCPs to a certain number of patients but reserves the right to restrict enrollment with that PCP if access to or quality of care are affected. If the Enrollment Broker notifies the State that a provider has reached 1200 patients, the State begins closely monitoring that provider's future enrollment levels. Monitoring of higher-volume PCPs is conducted to ensure

access to care and compliance with quality standards. The State contacts the MCO or MCOs with which the provider has contracted to notify the MCO of the enrollment level and to determine whether the MCO has any record of access problems with the provider. A provider may be restricted from additional enrollments or may have patients disenrolled to another provider.

2. X The State ensures adequate geographic distribution of PCPs within MCOs. Please explain.

   See previous discussions regarding distance and travel time standards and monitoring.

3. X The State designates the type of providers that can serve as PCPs. Please list these provider types.

   - *General Practitioners*
   - *Obstetricians/Gynecologist*
   - *Pediatric and Family Advanced Practice Nurses*
   - *Certified Nurse Midwives –practicing under the supervision of a physician*
   - *Physician Assistants -practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics, or Obstetrics/Gynecology who also qualifies as a PCP*
   - *Federally Qualified Health Care Centers*
   - *Specialists that are willing to fulfill PCP responsibilities for selected members with special needs and/or conditions*

c. Specialist Capacity Standards

1. X The State has set capacity standards for specialty services. Please explain.

   The State requires one fulltime equivalent physician with pediatric training for every 200 members. Otherwise, the State does not set specific numeric standards for specialists. Instead, the State requires the MCO to have a network capable of meeting the needs of all members requiring specialty care. If medically necessary care is not available within the MCO network, the State requires the MCO to pay for out of network providers to provide the services.

2. X The State monitors access to specialty services. Please explain

how often and how monitoring is done.

The State monitors accessibility and availability of specialists during readiness review by requiring the MCO to submit a list of all specialists, identifying any special experience or practice limitations of each specialist. The State reviews the list and determines if there are sufficient numbers of all specialty types identified in the MCO network, and if not, requires the MCO to submit a plan describing how it will assure that all specialty care needed by its members will be provided. The MCO must show sufficient numbers of specialty types or a sufficient plan for assuring provision of all the specialty types before it passes readiness review. If the MCO does not have a specialist in its network that can provide the medically necessary care required by a member, the MCO is contractually required to pay out of network providers to provide the care.

The State also monitors the provider directories that each MCO provides for inclusion in the enrollment kit and for enrollees who request a new provider directory. The provider directories are required to show specialists within each MCO network. The State reviews the directories for accuracy and clarity of all information included in the directories, and also to spot check the specialists that are included in the directory.

Weekly reports are submitted to the Enrollment Broker demonstrating PCP network and capacity. The following reports are furnished to the State with the frequency of reporting noted parenthetically: Network Provider Directory (quarterly); Provider Network Termination Report (monthly); Encounter data reports (monthly); Claims Aging and Summary Reports (monthly); Focus Studies (annually); Utilization Management reports(quarterly); Member Advocate Report (quarterly) and Behavioral Health utilization management reports (quarterly).
Access to specialty care issues are identified through complaint logs submitted by the MCOs and Enrollment Broker, through the State's internal complaint process, and through fair hearing logs. The State has reviewed these items and compared them to the EQRO's findings from member surveys reported in the Quality of Care and Services section of this Waiver renewal submission (SectionC.1.(c)). The state has identified no discernible trends at this time.

3. _ The State requires particular specialist types to be included in the

MCO network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. speciality to enrollee ratio. If specialists types are not involved in the MCO network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

Specialist Provider Type	Adult	Pediatric	Standards
Addictionologist and/or Certified Addiction Counselors			
Allergist/Immunologist			
Cardiologist			
Chiropractors			
Dentist			
Dermatologist			
Emergency Medicine specialist			
Endocrinologist			
Gastroenterologist			
Hematologist			
Infectious/Parasitic Disease Specialist			
Neurologist			
Obstetrician/Gynecologist			
Oncologist			
Ophthalmologist			
Orthopedic Specialist			
Otolaryngologist			
Pediatrician			
Psychiatrist			
Pulmonologist			
Radiologist			
Surgeon (General)			
Surgeon (Specialty)			
Other mental health providers (please specify)			
Other dental providers(please specify)			

Specialist Provider Type	Adult	Pediatric	Standards
Other (please specify)			

IV. Capacity Monitoring

Previous Waiver Period

a. _ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint].

The State limited PCPs to 1500 clients, across all plans in which the PCP participated. This was tracked by the Enrollment Broker, who notified the State when any PCP reached 1200 clients. If the Enrollment Broker notifies the State that a provider has reached 1200 patients, the State begins closely monitoring that provider's future enrollment levels. Monitoring of higher-volume PCPs is conducted to ensure access to care and compliance with quality standards. The State contacts the MCO or MCOs with which the provider has contracted to notify the MCO of the enrollment level and to determine whether the MCO has any record of access problems with the provider. A provider may be restricted from additional enrollments or may have some patients disenrolled to another provider.

The State also monitors to ensure adequate providers through review of quarterly complaint reports from the MCOs and STARline, the annual member and provider satisfaction surveys conducted by the State's EQRO*, which includes questions about enrollees' ability to access care.*

Monitoring of provider capacity did not indicate any deficits.

Upcoming Waiver Period -- For items a. through l. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.
Please indicate which of the following activities the State employs:

a. X Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b. _ Measurement of referral rates to specialists.

c. _ Provider-to-enrollee ratios

d. X Periodic MCO reports on provider network

e. _ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f. X Tracking of complaints/grievances concerning capacity issues

g. _ Geographic Mapping (please explain)

h. _ Tracking of termination rates of PCPs

i. _ Review of reasons for PCP termination

j. X Consumer Experience Survey, including persons with special needs

k _ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a. _ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the MCO:

a. X Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

b. X Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. X Health education/promotion. Please explain.

The State requires each MCO to develop and implement a health education plan for its members. The plan must be reviewed and approved by the State prior to implementation. All health education activities and materials must also be prior approved by the State.

d. X Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO, taking into account professional standards

e. X There is appropriate and confidential exchange of information among providers.

f. X Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g. _ Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h. X Case management (please define your case management programs)

Care coordination is a specialized care management service designed to ensure that all members receive necessary care and that both in-network and out-of-network care is integrated as much as possible. Care coordination includes but is not limited to: identifying physical health, mental health, and long term support needs; developing a care plan to address the unique needs of each member; ensuring timely access to providers and services; and coordination of all plan services with social and other services delivered outside the plan, as necessary and appropriate. The care coordinator is also responsible for monitoring the members in care coordination, periodically reviewing the member's needs and care plan, and reassessing members when their needs change.

The process of care coordination begins at the time of enrollment. The HMO screens each enrolling member to identify the member's perceptions of his/her existing health condition and services being received. This screen helps the HMO quickly identify members that require immediate attention. Within 30 days of a high-need member enrolling, the HMO must review this information and contact the member for a complete assessment and care plan.

The HMO furnishes a care coordinator to each member who requests one, who is receiving long term care services at the time of enrollment, or whose HMO assessment indicates complex health or support needs. The care coordinator works with the member, the member's family, and the

member's PCP and other service providers to develop a seamless plan of care that addresses primary, acute, and long term care service needs. If the member is eligible for Medicare, the care coordinator becomes familiar and communicates with the member's Medicare providers and services in order to integrate the care received through the two programs. Care coordinators have the authority to authorize and refer members for all long term care services and some acute care services. In addition to working with the member, the family, and all Medicaid and Medicare providers, the care coordinator also works with community organizations such as government agencies, social service agencies, and civic and religious organizations that provide needed non-Medicaid services.

Within these parameters, each HMO has customized its approach to care coordination.

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a. _ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

- *MCO must ensure that the care of newly enrolled members is not disrupted or interrupted.*

  The State requires MCOs to continue a member's existing acute, long term, behavioral health, and specialty care until the MCO assesses the member and makes any needed changes to the existing plan. The State worked closely with the MCOs during program implementation to coordinate the transition to managed care. This included educating providers about how to work with MCOs during this critical phase. The State also monitored how many new clients with existing service plans received MCO assessments within their first month of enrollment. Because so many new members were enrolled during the first month of mandatory participation, the MCOs had some problems assessing all new members during the first month of enrollment. The State required the MCO to report on the number of enrollees who remained unassessed past one month, and to develop corrective action plans for

completing the assessments. In the meantime, the State worked closely with the plans to ensure that no services were interrupted during the transition period. This included the contractual obligation to pay out of network providers until a new service plan could be established.

- *Pregnant members with 12 or fewer weeks remaining before the expected delivery date must be allowed to remain under the care of the member's current OBGYN through the postpartum check-up.*

  The State monitored this requirement through review of client and provider complaint reports. The State encountered no problems with this issue during the previous waiver period.

- *HMO must pay for member's existing out of network providers until records, clinical information and care can be transferred to a network provider.*

  The State requires the MCOs to continue a member's existing plan of care until the MCO assesses the member and makes any needed changes to the plan. The State worked closely with the MCOs to ensure a smooth transition for all clients who were receiving care prior to their enrollment in managed care. The MCO was allowed to require the provider to submit claims in accordance with State approved procedures. On an ongoing basis, the State monitors this requirement through review of client and provider complaint reports, and the annual onsite review of MCO contract compliance. The State encountered no problems with this issue during the previous waiver period.

- *HMO must provide or pay for out of network services for members who move out of the service area through the end of the period for which capitation was paid.*

  The State requires MCOs to pay for a member's care through the end of the period for which capitation is paid, regardless of the circumstances surrounding the client leaving the plan. The MCO does have the right to require the provider to submit claims in accordance with State approved procedures. The client shows in the State system as a member of the MCO until the period for which capitation was paid is over; thus any provider billing the State directly for a service for this client is denied payment and directed to bill the MCO. The State encountered no problems with this issue during the previous waiver period.

- *HMO must provide care coordination to members with chronic or complex conditions, or who request a care coordinator.*

  Care coordination is an integral piece of the STAR+PLUS program. The State has worked very closely with the MCOs since before program implementation to work through issues relating to care coordination. While each MCO structures care coordination differently, each MCO has made changes to their care coordination processes since program implementation as they gain experience, resulting in a continuous quality improvement effort. The State has held numerous conference calls and meetings with the MCOs to discuss care coordination. In addition, the State conducted a preliminary onsite review of care coordination a few months after the program began. During this review, the State examined MCO policies and procedures and care coordination records, and interviewed care coordinators to determine whether the MCOs were meeting contractual obligations and whether any MCO-specific processes should be modified to improve the care coordination provided to members. Additional monitoring was conducted through the EQRO's study of care coordination. This study provided a baseline structure and process look at care coordination. The ongoing studies of care coordination completed by the EQRO for FY 2000 and FY 2001 are described in the following section, B.VI.a Upcoming Wavier Period, since these activities form the basis for continued and evolving monitoring of care coordination. The recent studies provide the most comprehensive look at care coordination from the consumer and/or family member viewpoint and these findings/observations will be where the next stage in the EQRO evaluation of care coordination will begin.

c. _ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services).

d. _ [Required for all elements checked in the previous waiver submittal if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PHP providers.

Please describe how this issue is being addressed in the PHP program.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above?

Care coordination is monitored on an ongoing basis . The State performs various activities with the MCOs and EQRO to monitor care coordination services, including: 1) reviewing and resolving member complaints involving care coordination services, 2) reviewing quarterly care coordination reports submitted to the State, 3) convening ad hoc meetings between the State and care coordination staff on care coordination policies and activities, and 4) working with the EQRO on care coordination studies. The EQRO studies have provided an avenue to identify care coordination issues and evaluate them overtime, each study delving more deeply into specific areas. The most recent studies involved one-on-one interviews with members and their caregivers on their perceptions, knowledge and satisfaction with care coordination services. Additional information/summaries of the EQRO's studies on care coordination can be found in Section C. Quality of Care and Services of this waiver renewal submission. The instrument used in these interviews was a collaboration between a national expert on care coordination for persons with disabilities, State and EQRO staff. Training for the EQRO staff conducting the interviews was also provided by the national expert. A care coordination video was produced by the EQRO with assistance from the State, with the purpose being to educate and inform stakeholder groups and care coordination staff. The video tells the stories of five STAR+PLUS members with high service needs. Results of the Care Coordination Satisfaction Survey can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm***.
The STAR+PLUS Care Coordination video, identified as ***Attachment 5****, will be sent as a separate unattached video tape.*

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO to coordinate health care services excluded from the capitated waiver with:

1. _ Mental Health Providers
2. _ Substance Abuse Providers
3. X Local Health Departments
4. X Dental Providers (*EPSDT*)
5. X Transportation Providers
6. _ HCBS (1915c) Service
7. _ Developmental Disabilities
8. X Title V Providers
9. X Women, Infants and Children (WIC) program
10. _ Indian Health Services providers
11. _ FQHCs and RHCs not included in the program's networks
12. _ Other (please describe)

The State requires the MCOs to coordinate or provide referrals to all of the providers checked above, as well as other community providers. Coordination of all aspects of a client's care is expected, even if the needed care is a service not included in the MCO's capitation. Care coordinators receive training regarding available services in the community to which STAR+PLUS clients may need to be referred, and they can follow up with the external service providers when appropriate to coordinate with the client's in-network services.

Section C. QUALITY OF CARE AND SERVICES

I. Elements of State Quality Strategies: This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a. _ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:

b. X [Required] Describe the results of monitoring MCO adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint].

The MCO must submit an Annual QIP Summary Report to the State. The report provides summary information on the MCO's QIP system during the past year and proposed changes for the next year. Such changes must be approved by the State prior to implementation. The State's EQRO also reviews the MCO QIP for adherence to standards during the EQRO annual onsite review. The report for the 2001 State Fiscal Year is part of the EQRO Annual State Report. The State Reports and the Onsite Reviews can be found on the STAR+PLUS website at ***http://www.hhsd.state.tx.us/starplus/reports_contracts.htm****.*

c. X [Required for MCOs] Summarize the results of reports from EQRO. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint].

During the 2000 – 2001 period the EQRO conducted a general consumer satisfaction survey, annual consumer behavioral health satisfaction surveys, annual dual eligible satisfaction surveys, annual provider satisfaction surveys, and an annual onsite review of MCO contract compliance. A focused study regarding Care Coordination was also performed and is included in this section. In addition to the above, annual focused studies in the areas of Depression Management, Diabetes Management, and Care Coordination were also completed by the EQRO. The focused studies are examined under section C.VII.c Reference documents for the above studies are attached as indicated in the various sections.

1). A separate General Consumer Satisfaction Survey was conducted for SFY 2000 and SFY 2001. Respondents generally rated the STAR+PLUS health plans as positive. Out of a possible score of 10, consumers rated their satisfaction with their personal Doctor/Nurse, Specialist, Overall Care, and Health Plan as 8.4/8.3, 8.8/8.5, 8.2/8.0, and 7.8/7.8 for the 2000/2001 SFYs, respectively. The report also indicates that the results of the surveys compared favorably with national results for both commercially insured and Medicaid covered adults. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm***

2). The results of the two Behavioral Health Satisfaction Surveys indicated that most respondents were generally satisfied with the behavioral health services provided by the STAR+PLUS program (77% in 2000 & 71 % in 2001). They were also generally satisfied with care outcomes (53% in 2000 & 81% in 2001). An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

3). In addition to the behavioral health satisfaction surveys discussed above, there was also a general STAR+PLUS Behavioral Health Study performed. This study focused on the issues of access to care, coordination of care, and continuity of care as they impact clinical outcomes. More specifically, the "study examined whether relationships existed between specific clinical process (service) and outcome variables …" Results from the study indicated that members that utilized higher rates of outpatient behavioral health visits also displayed reduced rates of ER and inpatient care. This result was true regardless of the diagnosis of the individual. This result was even stronger if medication visits were excluded from the analysis, "suggesting that medication monitoring is not a substitute for regular behavioral health outpatient visits. "Continuous enrollment also was indicative of less ER and inpatient usage, "suggesting that continuity and access to care is crucial to good clinical outcomes." Additional findings indicated that the type of physician prescribing a psychoactive medication was not related to ER and inpatient usage (with the exception of those individuals with a diagnosis of schizophrenia). Older psychoactive medications prescribed for depression or schizophrenia were not more likely to be associated with increased ER or inpatient utilization. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

4). The initial Dual Eligible Satisfaction Survey (2000) was designed to be an initial assessment of dual eligible members perceptions of long term care services in the STAR+PLUS program. The results of that evaluation indicated that, in general, long term care service recipients were satisfied with those services and did not find it difficult to sign up for them. However, if dissatisfied, these members often did not notify the HMOs of their concerns. The second dual eligible satisfaction survey (2001) utilized a revision of the Care Coordination Survey instrument to measure satisfaction. The results of that survey indicated that most respondents: (1) rated the care coordination services they received as "good, very good, or excellent" (83%); indicated that it was "somewhat easy" or "easy" to get help from a care coordinator (93%); were included in decision making about their services (77%); reported telling their Medicare doctor that they were enrolled in STAR+PLUS (69%); and reported discussing care coordination with their Medicare doctor (50%). These results appeared to be rather uniform across all STAR+PLUS health plans. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

5). Provider Satisfaction Surveys conducted for both years generally produced comparable results. Three provider types (PCP, Specialists, & Long Term Care) were involved in the surveys and overall satisfaction was considered neutral to negative. On a five (5) point scale for the 2000 and 2001 studies, the PCPs scored 2.79 and 2.75; the specialists, 2.67 & 2.72; and the long-term care providers, 2.25 & 2.62, respectively. Additional information from the reports indicated that the PCPs and the specialists were more dissatisfied with the administrative and organizational aspects of the program (e.g. paperwork and reimbursement), and relatively more satisfied with the clinical provisions of the program (e.g. appropriate coverage, drug benefits). Long term care providers differed somewhat from the PCPs and specialists in the addition of adding the amount of paperwork, care coordination, and customer service to the areas where they were mostly satisfied. They coincided with the other provider groups in approving of the clinical care provisions of the program. Long term care providers also agreed with the other provider groups in being dissatisfied with reimbursement adequacy, and added timely claims payment as an additional concern. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

6). Onsite reviews: In the 2000 onsite review, there were three participating HMOs evaluated in seven different areas: Administration, Access/Utilization Management, Quality Improvement, Provider Services, Member Services, Health Information Management, and Care Coordination. On a scale of 1-4, with a score of three accepted as meeting expected levels of performance; Access Plus, Americaid, and HMO Blue respectively, scored 3/6, 6/6, & 6/6 areas as acceptable. In 2001 only HMO Blue and Americaid were evaluated as Access Plus had discontinued its STAR+PLUS operations. The results of that survey indicated that HMO Blue scored 4 of 4 acceptable areas and Americaid 3 of 4. The individual HMO reports for the 2000 and 2001 onsite reviews can be found on the STAR+PLUS website at ***http://hhsc.state.tx.us/starplus/reports_contracts.htm****. Note that the 2001 reports do not include a plan summary.*

7). Care Coordination is a requirement of the HMOs participating in STAR+PLUS and is designed to help clients obtain services specific to their particular health care needs. Member satisfaction with care coordination was a topic of study during both the SFY 2000 and 2001 studies. In addition, the 2001 study examined the care coordination process itself, and the relationship between care coordination activity and the level of member satisfaction with care coordination services. The 2001 study also examined consumer/caregiver experiences with the process. The results of the studies were generally consistent across the two year period. Findings from the 2000 study indicated the health plan interventions and service authorizations were tied to member need. Satisfaction with the care coordination services in the 2000 study also indicated that most members felt "good", "very good", or "excellent" overall regarding the services, and most would also recommend their health plan to others. As with the 2000 study, the 2001 study also found that most members were satisfied with the care coordination services and would recommend their HMO to others. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

8). A Spot-Check program was also initiated by EQRO for the SFY 2000 and 2001 periods. These studies were intended to give some insight into HMO/BHO level of accessibility, information accuracy, and ability to communicate with members is both English and Spanish. For the initial SFY 2000 study both an initial and a follow-up survey were undertaken. Methodological differences between the two studies made comparison somewhat difficult, but improvement was noted following first study feedback to the HMOs. The SFY 2001 study scope was generally not comparable to the SFY 2000 study. The results of that study indicated that "while the HMOs/BHOs are not at 100% compliance…representatives

appear to be knowledgeable of the STAR+PLUS benefits." The primary objective of the Spot-Check program was to identify accessibility issues that could be improved within the HMO/BHO. In that regard the studies appeared to be successful. Copies of the Spot-Check studies can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

d. X [Required for PHPs and MCOs] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint].

Results of the medical record audits conducted by the State's EQRO are part of the EQRO MCO Onsite Reviews, which are included in the annual plan report on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm****.*

e. _ [MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States which contract with MCOs and element d is required for States which contract with PHPs. The State:

a. X Includes in its contracts with MCOs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of MCOs in their contracts as an attachment to this section **(Attachment 6)**.

b. X Monitors, on a continuous basis, MCOs adherence to the State standards, through the following mechanisms (check all that apply):

1. X Review and approve each MCOs written QAP. Such review shall take place prior to the State's execution of the contract with the MCO.

2. X Review each MCOs written QAP on a periodic schedule after the execution of the contract. Please specific frequency: *Annual*

3. X On-site (MCO administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) *annually* for each MCO or attach the scope of work from the EQRO contract as an attachment to this section.

4. X Conducts monitoring activities using (check all that apply):

(a) X State Medicaid agency personnel

(b) X Other State government personnel (please specify):

Texas Department of Human Services and Texas Department of Mental Health and Mental Retardation personnel

(c) X A non-State agency contractor (please specify):

5. _ Other (please specify):

c. X Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. The State is currently reprocuring the EQRO contract. The name of the entity will not be available until late August 2002.

2. The entity type is:
(a) _ A Peer Review Organization (PRO).
(b) X A private accreditation organization approved by HCFA.
(c) _ A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the EQRO:

The EQRO will conduct annual consumer satisfaction surveys, an onsite review, focused studies on acute and/or chronic conditions. The workplan for the next waiver period is included as ***Attachment 7****.*

d. X Has established a system of periodic medical audits of the quality of, and access to health care for each MCO on at least an annual basis. These

audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:**

1. The entity type is:
   (a) _ State Medicaid agency personnel
   (b) _ Other State government personnel (please describe):
   (c) _ A non-State agency contractor to the State (please describe):
   (d) X Other (please describe):

   By federal law, the following activities must be performed by the EQRO for Medicaid: validation of MCO performance improvement projects required by the State and performed during the preceeding 12 months; validation of performance measures that the State requires that MCOs report during the previous 12 months; review MCO compliance with state standards regarding availability of services, continuity and coordination of care, coverage and authorization of services, establishment of provider networks, enrollee rights, confidentiality, enrollment and disenrollment, grievance systems, subcontractual relationships and delegation, use of practice guidelines, health information systems, mechanisms to detect under and over-utilization of services. The EQRO will also be required to assist in the validation of patient level claims or encounter data, in the implementation of consumer and provider satisfaction surveys and in the quality of care focused studies.

2. Please attach the scope of work for the periodic medical audits.

e. X Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PHPs).

f. X Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g. X Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality

measurement and improvement and consumer satisfaction.

h. _ Plans to develop and implement the use of QISMC in its quality oversight of MCOs. (QISMC is a HCFA initiative to strengthen MCOs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for States) Please explain which domains will the State be implementing (check all that apply).

1. _ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation

2. _ Domain 2 - Enrollee Rights: Date of Implementation

3. _ Domain 3 - Health Services Management : Date of Implementation

4. _ Domain 4 - Delegation: Date of Implementation

i. _ Other (please describe)**:**

II. Coverage and Authorization of Services

Previous Waiver Period

a. _ During the last waiver period, coverage and authorization of services were different than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

The State monitored authorization of services and under/overutilization through review of quarterly client complaint reports, and annual client and provider satisfaction surveys. The State also received information in this area from informal provider complaints. The State has ongoing quarterly workgroups with each provider type, such as day activity and health service agencies and home health agencies. The major issues relating to

authorization processes were resolved, but the HMOs and provider groups continue to meet on a periodic basis to handle any additional issues that arise.
The State found that authorizations for services during the time ACCESS STAR+PLUS and ACCESS+PLUS phased out of the program were an issue due to the volume of members transitioning. The State and MAXIMUS worked closely with the terminating and the receiving health plans to facilitate a smooth transition.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with MCOs:

a. X Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b. X Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition:

- *Medically necessary health services means health services other than behavioral health services which are:*
- *Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;*
- *Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health condition*
- *Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or endorsed by professionally recognized health care organizations or governmental agencies;*
- *Consistent with the diagnoses of the conditions; and*
- *No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency*

c. X Provide that the MCO furnishes the services in accordance with the specification or definition of "medically necessary services".

d. X Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. X Specific time frames for responding to requests,

2. X Requirements regarding necessary information for authorization decisions,

3. X Provisions for consultation with the requesting provider when appropriate,

4. X Providing for expedited response for urgently needed services

5. X Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. X Criteria for decision on coverage and medical necessity are updated regularly.

7. X Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. X A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

9. X Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

   (a) X Criteria used in denying or limiting authorization

   (b) X Information on how to request reconsideration of the decision.

(c) _ Other (please describe):

10. X Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. _ Mechanisms to detect both underutilization and over utilization of services.

12. _ Other (please describe):

e. _ Other (please describe):

III. Selection and Retention of Providers

Previous Waiver Period

a. _ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored contract compliance in the areas that have been checked for the previous waiver period [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

The State required MCOs to contract with significant traditional providers (STPs) during the first three years that Medicaid managed care is implemented in a service area. The State determined which providers qualified as STPs based on how many Medicaid clients they had prior to managed care. In addition to designating acute care STPs, the State designated all long term care providers as STPs. The efforts of the MCOs to contract with STPs were monitored through monthly reports to the State identifying the STPS in the MCO's network. Most STPs chose to participate in at least one of the MCOs, and many chose to participate in all the networks. Prior to the end of the third year of operation of Medicaid managed care, providers were aware that the STP protection would go away. MCOs reported that no contracts were terminated based on the absence of the STP protection. From that time forward, MCOs have managed their provider networks based on their need, which is established using specific protocols dealing with geographic access, specialty, service type, member preference and STP status. The State and EQRO conducts monitoring of provider networks in the areas of

availability, accessibility and adequacy of health and long term care services. MCOs provide monthly provider network change reports to ensure that sufficient numbers and types of providers are maintained in each MCO's network. The State convenes quarterly MCO/provider meetings which offer individual providers the opportunity to meet MCO staff and discuss contracting issues. These ongoing meetings were initiated in January 2001 and provide a forum for improving provider/MCO communication.

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each MCO implements a documented selection and retention process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires MCOs to (please check all that apply):

a. X Develop and implement a documented process for selection and retention of providers.

b. X Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c. X Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. X Initial credentialing

2. X Performance indicators, including those obtained through the following (check all that apply):

   (a) X The quality assessment and performance improvement program

   (b) X The utilization management system

(c) X The grievance system

(d) X Enrollee satisfaction surveys

(e) _ Other MCO activities as specified by the State.

d. X Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e. _ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State

f. X Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. _ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h. _ Other (please describe):

IV. Delegation

Previous Waiver Period

a. _ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:

b. _ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by MCOs, the State Medicaid

Agency:

a. X Reviews and approves (check all that apply):

1. _ All subcontracts with individual providers or groups

2. X All model subcontracts and addendums

3. _ All subcontracted reimbursement rates

4. _ Other (please describe):

b. X Requires agreements to be in writing and to specify any delegated responsibilities.

c. X Requires agreements to specify reporting requirements.

d. X Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. _ Monitors to ensure that MCOs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f. _ Ensures that MCOs monitor the performance of the entity on an ongoing basis.

g. _ Monitors to ensure that MCOs formally review the entity's performance at least annually.

h. X Ensures that MCOs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i. _ Other (please explain):

V. Practice Guidelines

Previous Waiver Period

a. _ During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:

b. _ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of

the 1995 preprint].

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Guidelines:

a. _ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b. _ Consider the needs of the MCOs enrollees.

c. _ Are developed in consultation with contracting health professionals.

d. _ Are reviewed and updated periodically.

e. _ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f. _ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g. _ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h. _ Other (please explain):

VI. Health Information Systems

Previous Waiver Period

a. _ During the last waiver period, health information systems were different than described in the waiver governing that period. The differences were:

b. _ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

c. X Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs.

The HMOs are contractually required to provide Acute Care and Long Term Care (LTC) encounter data on a monthly basis. A more comprehensive and consistent data set has been established. With the cooperation of the MCOs, a set of all encounters from September 1999 to current period is available for study. One plan that left the program has not provided the data for the period from September 1999 to August 2000.

The data is received by the 15th of the month for those claims paid to the provider by the plan during the previous month. The encounter data is integrated with enrollment data, capitation payments, assessment data, provider data, and reference data. The encounter data is considered highly accurate as indicated below:

Number of encounter records loaded	*3,550,537*
Number of unmatched Primary Diagnosis	*6,747*
Percent in error	*0.19%*
Number of unmatched Procedure/Service codes	*7,877*
Percent in error	*0.22%*

Encounter data is identified as paid, denied, reversed, and adjusted. Realizing that some of the denied encounters are ones with invalid diagnosis and procedure codes, efforts are in process to eliminate their submission so the denied will be those denied for cause and not bad data. The accuracy of the provider and assessment data is currently being evaluated.

The completeness and usability of the encounter data is still being evaluated. It appears to be consistent with other data from the MCOs. Each variance between the encounter data and other source data is being examined in order to make that determination. This process is exemplified by comparing MCO produced utilization data with corresponding data produced from the encounter data. Discrepancies are noted and investigated as to possible cause.

d. X The State uses information collected from MCOs as a tool to monitor and evaluate MCOs.

e. _ The State uses information collected from MCOs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs and/or providers).

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs systems:

a. X Provide information on
1. X Utilization,
2. X Grievances,
3. _ Disenrollment.

b. X Collect data on enrollee and provider characteristics as specified by the State.

c. X Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO is capable of (please check all that apply):

1. X [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. X [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

3. X Verifying the accuracy and timeliness of data

4. X Screening data for completeness, logic and consistency

5. X Collecting service information in standardized formats to the extent feasible and appropriate

6. _ Other (please describe):

d. X Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1. X Health services (please specify frequency and provide a description of the data and/or content of the reports)

The State requires the MCOs to submit semiannual reports on utilization of physical, behavioral, and long-term care health utilization. In addition, the State and the MCOs have cooperated in ongoing efforts to refine the definitions of the Utilization Management Tables in order to improve the accuracy of the reported data. A sample of the various utilization reports is included as ***Attachment 8.***

2. X Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

The State has continued to work with EQRO and the MCOs in developing focused studies regarding outcomes of care. The depression and diabetes focused studies are discussed in section C. VII. c. As the State is currently rebidding the EQRO contract, upcoming focused studies will be decided on by the State and the new EQRO.

3. X Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

The data is provided monthly by each plan based on the encounters paid to the providers in the previous month. The record layout for the data and descriptions of specific coding conventions is included in ***Attachment 9****.*

4. _ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e. X Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f. X Ensure that information and data received from providers are accurate, timely and complete.

g. X Allow the State agency to monitor the performance of MCOs using systematic, ongoing collection and analysis of valid and reliable data.

h. X Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i. _ Other (please describe):

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a. _ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available.

The State contracted with the EQRO to monitor MCO compliance with contract requirements, including the quality standards included in the contract. EQRO is also required to monitor the MCO quality improvement plans, and conducts a number of activities each year to measure quality. The results for SFY 2000 - 2001 are available in the onsite review at ***http://hhsc.state.tx.us/starplus/starplus.htm****.*

c. X The State or its MCOs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

1). The diabetes focused study assessed medical records, administrative, and pharmacy data to document the rate of key clinical performance measures. The outcomes over the 2000 and 2001 studies indicate some areas of improvement and some decline from year to year. HbA1c & lipid panel testing declined. Documentation of educational intervention also declined over the two year study period. Retinopathy screening, nephropathy screening, and foot examinations all increased in frequency. However, retinopathy and foot examinations remain below national benchmarks set by CDC and NCQA. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm****.*

2). The 2000 & 2001 depression focused studies were designed to examine the treatment practices of PCPs in a managed care setting. It addressed some of the shortcoming of a previous depression study done for SFY 1999. The year to year results indicate some improvement and some decline in the documented records. Improvement was evidenced in: (1) antidepressant medication documentation (33% - 53%); (2) documented referral to behavioral health specialist (11% - 23%); and (3) of those receiving antidepressant, 84% had received at least 75% of the minimum targeted dosage, compared to the previous figure of 47%. Declines were noted in: (1) members with documented symptom response to medication declined from 20% to 17%; and (2) members prescribed an antidepressant medication, who also had at least three follow-up visits documented, dropped from 33% to 20%. It was felt that this series of two studies provided a baseline for continuous quality improvement in this area. An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm****.*

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a. X Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards which include (check all that apply):

1. X A policy making body which oversees the QAPI

2. X A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3. X Active participation by providers and consumers

4. X Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5. _ Other (please describe):

b. _ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required.

c. _ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency.

d. X Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

The State works with its EQRO and the MCOs to develop focused studies to obtain information about outcomes of care. The EQRO will conduct focused studies. The workplan for the next waiver period is included as ***Attachment*** **6**.

e. X Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f. X Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g. _ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h. X Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i. X Select and prioritize topics for projects to achieve the greatest practical

benefit for enrollees.

j. X Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k. X Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l. X Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m. X Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n. _ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o. _ Use a sampling methodology that ensures that results are accurate and reflective of the MCOs enrolled Medicaid population.

p. _ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q. X Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r. _ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s. X Administer their QAPI through clear and appropriate administrative arrangements.

t. X Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u. _ Other (please describe):

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver renewal request must demonstrate that it was cost-effective during the previous two-year waiver period (Years 1 and 2) and must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver in the upcoming two-year waiver period (Years 3 and 4).

With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised preprint is optional.

- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).

- States are not being held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.** In

addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.

· Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.

· A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells)**. If a waiver program does not cover all categories of service, the State should modify the spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

· The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. HCFA may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:
In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

• In order to determine cost-effectiveness, States must first document the number of member months participating in the waiver program for the previous waiver

period (Year 1 and Year 2). They must then estimate the number of member months for the target population which will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4) See Appendix D.II, Steps 1-4. The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2.

- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). If the State is proposing to use a different methodology for Years 3 and 4, please document all differences between the methodologies. Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.

- Statistically valid (as defined by the State's actuary) without waiver cost and eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract--inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18). Without waiver costs must be developed for all Years 1 - 4.

- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs

related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractor did not exceed the UPL in the past two years and will not exceed the UPL in the future two years (Appendix D.VIII, Steps 36-37), and costs under the waiver did not exceed costs without the waiver costs in the previous period and will not exceed without waiver costs in the future (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

___X____ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Star+Plus Medicaid Financial Officer: Merle L. Moden

Telephone Number: 512/794-6870

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract The response to this question should be the same as in A.II.e.

a. X Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs)
b. _ Other risk (partially-capitated--PHP)
c. _ Non-risk. Please use Section C of the PCCM initial application.
d. _ Other (please explain):

II. Member Months: Appendix D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary

by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

a. Population in base year data

1. X Base year data is from the same population as to be included in the waiver.

2. _ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V).

At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This preprint will be updated based upon the outcome of that workgroup.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Regional Offices approve annual UPLs and contract rates developed by States. They are authorized to approve UPLs and contract rates that fall under the methodologies granted under the original and subsequent waiver authority. Modifications to the UPL development methodology should be approved through a waiver modification as explained in the instructions to this preprint.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or services were used in the Without Waiver costs for the upcoming waiver period than in the previous waiver period.** Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

Step 7: **UPL Adjustments:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Preprint Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through l. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to it without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g.

reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: HCFA's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the HCFA Regional Office may require more documentation during the UPL and contract rate approval process.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a. _ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1. X We assure HCFA that DSH payments are excluded from base year data.
2. _ We assure HCFA that DSH payments are excluded from

adjustments.

3. _ Other (please describe):

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.
Basis:

1. X IBNR adjustment was made. Please indicate the number of years used as basis *Calendar year 1997*
   i. X Claims in base year data source are based on date of service. *
   ii. _ Claims in base year data source are based on date of payment.
   * Estimates for pharmacy services were calculated on a date of payment basis.

2. _ IBNR adjustment was not necessary (Please explain).

Methodology:

1. X Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.**
2. _ Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.
Basis:

1. X State historical inflation rates
   (a) Please indicate the years on which the rates are based: *Inflation base years are State Fiscal Year 1993 through 1997.*
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): *Mean rate of increase for the five year period.*

2. _ Other (please describe):

d. Third Party Liability(TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and methodology:

1. _ No adjustment was necessary
2. X Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3. _ State collects TPL on behalf of MCO enrollees
4. _ The State made this adjustment:
5. _ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs.
6. _ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1. _ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.
2. X Other (please describe):

   Costs arising from FQHC/RHCs are included in projected costs used to develop both without waiver and with waiver costs. These costs accounted for about 0.005% of acute care costs in the Calendar Year 1997 base period.

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1. _ Payments outside of the MMIS were made. Those payments include (please describe):

2. _ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. X The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.
Basis and Methodology:

1. _ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.
2. _ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
3. X Other (please describe):

Pharmacy services are neither covered by nor included in capitation rates. These services are provided on a fee for service basis. The waiver includes only additional costs of pharmacy services (i.e., Medicaid-only managed care enrollees over 21 years of age receive unlimited medically necessary prescriptions rather than being limited to three per month under the traditional Medicaid program.)

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to it without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation (Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these costs

include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1. _ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to ___ percent of FFS service costs.
2. _ The State has chosen not to make adjustment.
3. X Other (please describe):

*The State has made no adjustments other than including the FFS cost of claims processing in the UPL and in the "with waiver" calculations excluding claims processing costs for HMO members and including claims processing costs for PCCM members.***

Methodology:

1. X Determine administrative costs on a PMPM basis by adding FFS claims processing administrative costs and dividing by number of total Medicaid FFS members**
2. _ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.
3. _ Other (please describe):

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1. X Claims data used for UPL development already included copayments and no adjustment was necessary.
2. _ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.
3. _ The State has chosen not to make adjustment.
4. _ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1. _ The State made this adjustment (please describe):
2. X The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

1. _ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.
2. X The State has chosen not to make adjustment.
3. _ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1. _ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.
2. _ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.
3. X Other (please describe):**

Not applicable

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1. _ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2. X The State has chosen not to make adjustment.
3. _ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1. X Expected State Medicaid FFS fee schedule increases between the base and rate periods.
2. _ The State has chosen not to make FFS price increases in the managed care rates.
3. _ Changes brought about by legal action (please describe):
4. _ Changes in legislation (please describe):
5. _ Other (please describe):

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1. _ The State made this adjustment (please describe):

2. X The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period. **

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

1. _ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.

2. X The State has chosen not to make adjustment.
3. _ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective eligibility back to birth for newborns.
Basis and Methodology:

1. _ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.
2. X The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.
3. _ Other (please describe):

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1. _ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.
2. X The State has chosen not to make adjustment.
3. _ Other (please describe):

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects states to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: **With Waiver Cost Adjustments** (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With

Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs when MCOs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1. X The State does not provide or require reinsurance or stop/loss for MCOs. No adjustment was necessary.
2. _ The State provides reinsurance or stop/loss (please describe):

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs.

Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs do not exceed the UPL:

c. Other Adjustments (Please list and describe the basis and methodology):

*The State and MCOs have a contractual profit sharing agreement, called an experience rebate. Please see **Attachment 10** for an explanation of the experience rebate.*

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO in the annual capitated rate approval. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or

less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V

Steps 19-29

The actuarial basis for the capitation rates for both MCOs and PHPs must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO's cost); and the contractor's community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

You may use other methods as well. If there are adjustments for stop-loss and reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1. X The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. **Please attach a description of the rate setting methodology** and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.
   (a) X Rates are set at a percent of UPL
   (b) _ Negotiation (please describe):
   (c) _ Experience-based (contractor/State's cost experience

or encounter data) (please describe):
(d) _ Adjusted Community Rate (please describe):
(e) _ Other (please describe):

2. X The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.

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3. X The State will submit all capitated rates to the HCFA Regional Office for prior approval.

b. X The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

The figures below show costs related to extra prescription drugs. Additional costs were incurred by the HMOs for the annual adult well checks and for waiving the 30 day spell of illness limitation for inpatient hospitalization. These costs are included in the capitation rate paid to the MCOs..

1. X The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.

Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period: $9,967,662. This amount must be built into the State's with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period: $15,210,093. This amount must be built into the State's with waiver costs for Years 3 and 4.

2. _ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services $16.53 (for Medicaid Only risk groups). This

amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services. The State paid $8,666,301 for these services during FYs 2000 and 2001. These costs include all inpatient expenses for admissions in excess of 30 days.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.** Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI
See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: **Appendix D.VII**

Steps 30-35: See instruction boxes.

VIII. Year 3 Aggregate Costs: **Appendix D.VIII**
See Instructions for C.VII Year 2 Aggregate Costs

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IX. Year 4 Aggregate Costs: **Appendix D.IX**
See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X

Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

Previous Waiver Period

a. _ During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint].

During the preceding Texas legislative session a bill (Senate Bill 30) was passed which related to fraud and improper payments under the State Medicaid program and the creation of a criminal offense. Senate Bill 30 included specific requirements for managed care organizations. Among others, the requirements were:

- *Not later than 30 days after execution of a contract, develop and submit to the operating agency for approval by the Commission a plan for preventing, detecting, and reporting fraud and abuse that conforms to guidelines developed by the operating agency with assistance from the Commission and the Office of the Attorney General.*

- *Require the MCO to report any known or suspected act of fraud and abuse to the operating agency for referral to the Commission for investigation*

As indicated above, the State's contract with the MCOs requires that they report any suspected fraud and abuse on the part of members or providers. The State Office of Investigations and Enforcement has developed its Managed Care Fraud and Abuse Compliance Guidelines, which are based on the model fraud and abuse compliance plan released by the US Office of the Inspector General. MCOs are provided training to ensure that the MCO Fraud and Abuse plans are adequate. There were only two referrals made to Fraud & Abuse during the last waiver period. We do not have the results of the formal investigation

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver

submittal(s) by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a. X The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO, by the State's claims processing system).

b. _ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits).

c. X The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan. The Managed Care Fraud & Abuse Model Compliance Plan is enclosed as attachment 16.

d. X The State has a specific process for informing MCOs of fraud and abuse requirements under this waiver. If so, please describe.

The State's contract with the MCO details and/or references fraud and abuse requirements under the waiver.

e. _ Other (please describe):

II. MCO Fraud Provisions

a. X The State requires MCOs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements.

As part of their fraud and abuse plans, each MCO has policies and procedures for preventing, detecting, investigating and reporting potentially fraudulent or abusive situations, per State contract requirements. APPENDIX Section 5.3.2.1-5.3.2.8. MCOs submit their plans, policies and procedures to the State Office for Investigations & Enforcement within HHSC for approval.

b. X The State requires MCOs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations

Section F. Special Populations

Note: Included in the previous waiver renewal was an Attachment, entitled "Interim Review Criteria for Children with Special Needs", dated October 5, 1999. Attachment F, Children with Special Health Care Needs Criteria, has also been included in this renewal.

I. General Provisions for Special Populations

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b.___ [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of Special Populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint].

c. ___ Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all items which apply to the State.

a.___ The State has a specific definition of special populations or populations with special health care needs. The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

b. **X** There are special populations included in this waiver program.

Please list the populations.

The STAR+PLUS program serves the SSI population, which includes people with disabilities and/or chronic and complex conditions. The State recognizes that STAR+PLUS members have special health care needs. Various populations served in Star+Plus include, but are not limited to the following groups:
Children with Special Health Care Needs, individuals with persistent and chronic mental illness and/or substance abuse, persons living with AIDS, elderly and non-elderly individuals
with physical disabilities, chronic and complex health conditions, and persons with developmental or sensory (vision and hearing) impairments. STAR+PLUS also serves a significant population of individuals of Asian Pacific descent.**

c. **X** The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

See previous Attachment A.III.b.1, MAXIMUS Outreach Organizations (see page 26)**

d. **X** The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1. X Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)

   One of the STAR+PLUS MCOs is planning a companion Medicare product which is expected to start in the fall of 2002, pending approval from CMS. Members choosing this STAR+PLUS plan will then have a choice of the Medicare companion plan. Better coordination of services is expected for those dually eligible members, including approximately 70 individuals below the age of 21 who could choose the

Medicare companion product. Additionally, there are a number of public forums in Houston which provide opportunities for enhanced coordination of services for STAR+PLUS members with special needs through information sharing and services updates. These forums include 1) quarterly meeting of local advisory committees (subcommittees of the local RAC) dedicated to persons with serious and persistent mental illness and/or substance abuse and children with special health care needs. Both of these meetings are convened by regional agency staff who are knowledgeable of other systems of care operated by HHSC, TDH, PRS and TDMHMR, which include Title V, Ryan White, and SAMHSA Health and substance abuse block grant funding. **

2.___ State/local funding sources
3._X_ Other (please describe):

In the past Texas has had a special focus on integrating Medicaid and PRS services for foster children through a grant the State Medicaid Office/HHSC received. Texas was one of six states that received a technical assistance grant through the Nathan Cummings Foundation. The grant is part of an initiative to improve the health of children; the specific grant objective was to facilitate a collaborative relationship between agencies which usually have very limited contact with each other (e.g., Medicaid and Child Protective Services). The states in the grant (Alaska, Massachusetts, New Mexico, Utah, California and Texas) agreed to focus on interagency efforts to improve the health care of children in state custody (foster care). The grant provided state Medicaid, health and child protective agencies with the opportunity to learn from their colleagues in other states and to share their progress.

In the area of Children with Special Health Care Needs, the Managed Care Advisory Committee on Children with Special Health Care Needs, a subcommittee of the local RAC, functions as the primary liaison to the HHSC staff who serve as the statewide coordinator for policy on services to

Children with Special Health Care Needs. This coordination and liaison function ensures that the statewide Title V Advisory Committee on Children with Special Care Needs is aware of CSHCN issues identified in STAR+PLUS.

The State Enrollment Broker works with the MCOs, community, advocacy, and consumer groups, along with public and private agencies, to identify the needs of special populations served in STAR+PLUS. **

An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at ***http://www.hhsc.state.tx.us/starplus/reports_contracts.htm.***

e. _X_ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1._X_ Access to services (please describe):

The State has addressed the process for monitoring access to services. Since so many members are considered in the special population, the monitoring process described in the previous section of the waiver is used for each special needs subpopulation (see Section B.II. Access and Availability Monitoring of this waiver application).**

2._X_ Quality of Care (please describe):

The State's monitoring for quality of care applies to all the STAR+PLUS members including the special needs populations. There are several extra components added to the quality review program including additional questions on the CAHPS survey, including questions on long term services. The HMO on-site surveys, conducted by the EQRO, include individual elements which address how the plans assess special needs populations. Additionally, the MCOs provides behavioral health education programs on topics such as: access to MCO behavioral health services, community resources, alcohol/substance abuse, mental illness, and other programs targeted for specific demographic populations.**

3._X_ Coordination of care (please describe):

For STAR+PLUS members that are receiving all preventive, primary, acute and long-term care services from the same HMO, the HMO must ensure that each member has a qualified PCP who is responsible for overall clinical direction and serves as a central point of integration and coordination of covered primary, acute and long-term care services. The HMO will furnish a Care Coordinator to all members who request one, or when the HMO has determined through an assessment of the member's health and support needs, that a Care Coordinator is required. The Care Coordinator shall be responsible for working with the member and service providers to develop a seamless package of care in which primary, acute and long-term care service needs are met through a single, understandable rational plan. Each member's plan must also be well coordinated with the member's family and community support systems. The Care Coordinator shall work as a team with the PCP and coordinate all STAR+PLUS services with the PCP. The HMO must identify and train certain members or their families to coordinate their own care to the extent of the member's capability. The HMO must empower its Care Coordinators to authorize and refer members for all long-term care services.**

4._X_ Enrollee satisfaction (please describe):

The State's EQRO completed consumer satisfaction surveys in 1999, 2000, and 2001 for STAR+PLUS members. ** An Executive Summary and Final Technical Report for this study can be found on the STAR+PLUS website at **http://www.hhsc.state.tx.us/starplus/reports_contracts.htm**.

5.___ Other (please describe):

f. _X_ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

The State's contract with the MCOs requires the MCOs and their

providers, to meet ADA requirements. The MCOs conduct on-site office visits as part of their credentialing process for the providers in their network, and these visits include a review of ADA compliance. **

g.___ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

II. State Requirements for MCOs

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. ___ [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of Special Populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint].

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or MCO.

a.___ The State has required care coordination/case management services the MCO shall provide for individuals with special health care needs. Please describe by population.

b.___ As part of its criteria for contracting with an MCO, the State assesses the MCO's skill and experience level in accommodating people with special needs. Please describe by population.

c.___ The State requires MCOs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe

by population.

d.___ The State has provisions in contracts with MCOs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If **not** checked, please explain by population.

e.___ The State collects or requires MCOs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.

g.___ The State requires MCOs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the conditions.
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the MCOs for the special populations in the waiver that differ from those requirements

described in previous sections and earlier in this section of the application. Please describe by population.

ATTACHMENT F

Children with Special Health Care Needs Criteria for All Service Areas

The following information is provided by each appropriate subset of children with special needs:

- The State's responsibilities in managed care programs enrolling children with special needs.
- The State's requirements for MCOs enrolling children with special health care needs.
- How the State monitors its own actions and that of its contracting MCOs and PHPs.
- For foster-care children only, the provisions which address the broader, unique issues occurring because of out-of-home, out-of geographic area placement.

State Responsibilities for Managed Care Programs Enrolling Children with Special Needs

- Public Process

  The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, consumer groups) during the development of the waiver program and has sought their participation in that process.

  The State held a series of public meetings prior to setting a schedule for the implementation of Medicaid managed care statewide. The public meeting in Houston was designed to solicit input from numerous stakeholders, including family members/caregivers of children with special health care needs. All of these meetings were announced publicly, in the Texas Register and to interested parties. At the Houston hearing, State agency representatives listened to assess the area's interest in Medicaid managed care and to any concerns the area had with managed care, the State gained a sense of what types of models would complement the community's infrastructure and ultimately serve individuals well. At that time, it became clear from the comments provided at the meeting that mandating children with special health care needs into a capitated MCO delivered service model was not optimal. After deliberation, the decision to allow children with special health care needs to volunteer into capitated MCO delivered services in STAR+PLUS was made. Based on that decision children have the choice between the PCCM model in STAR+PLUS or the capitated model in STAR+PLUS. Both the PCCM and the capitated models

are operated by MCOs.

At the next stage of development, the State's Request for Application (RFA) was developed for STAR+PLUS. . The RFA, which describes the program and outlines the managed care organization's responsibilities under Medicaid managed care, was developed with input from stakeholders, including advocates, consumers, providers, regional Department of Human Services staff, public health programs within the Texas Department of Health, and the Regional Advisory Committee. The RFA contains the contract used by the State to contract with MCOs, giving these stakeholders the opportunity to comment on both the RFA and the contract. An RFA is released for public comment at least 30 days before the final RFA is released for competitive bidding purposes. The State processes all comments and considers them in preparing the final RFA and contract

> ***In addition to these processes, a Regional Advisory Committee (RAC) was established in the Houston service area prior to the implementation of managed care. The Harris County RAC began formal meetings in November, 1996, and continues to meet to date, providing a mechanism for continuous public input into the 1915(b) waiver program. The RAC, is made up of advocates, consumers, providers, hospital representatives, managed care organizations, community based organizations, and State agency representatives. The RAC's initial objective is to provide input and to communicate to the state any issues concerning implementation of managed care in the area.***

The Houston RAC formed subcommittees at its own discretion, based on the interest of the RAC members. Issues addressed and subcommittees formed by each RAC reflect the committee's interests and the needs of the individual service area. One of the formal subcommittees of the Houston RAC is the subcommittee on Children with Special Health Care Needs, which meets quarterly at the local Shriners Hospital in the Houston medical complex. Two other subcommittees also meet regularly: the behavioral health subcommittee and the cultural competency subcommittee.

The subcommittee on Children with Special Health Care Needs is staffed by a physician in the regional HHSC office and is chaired by the Program Director for Title V services from the regional Department of Health. Membership is open to all interested parties and the meetings are well attended, with representation from a broad array of interests. Representatives from the following organizations attend regularly: local independent school districts, early childhood intervention programs,

HMOs, childrens advocacy groups, family support groups for parents of children with disabilities, physician pediatric specialty association, specialty hospitals, such as Shriners hospital, Advocacy, Inc. (federal protection and advocacy organization), and regional Department of Health managers. One parent who participates actively on the subcommittee is also a member of the statewide CSHCN Advisory committee, convened by TDH.

In addition to these components of the public process, the Texas Department of Human Services and the Texas Health and Human Services Commission (HHSC) work closely with advocates from statewide organizations, state legislators and their staffs, providers, hospitals, and managed care organizations in developing and refining the Medicaid managed care program. The agencies meet regularly with their contracting MCOs. State agency representatives routinely attend meetings involving all aforementioned stakeholders, as well as make presentations to those groups at their request. The State Medicaid Office also includes a Medicaid Managed Care report from STAR+PLUS as part of the Medical Care Advisory Committee (MCAC) agenda, providing MCAC members with information on the program and listening to any input provided by the Committee.
The Texas Legislature voted to require the formation of a state Medicaid managed care advisory committee in House Bill 2896, which was passed in the 76th Legislature. In response to this legislation, HHSC developed a statewide Medicaid Managed Care Advisory Committee (SMCAC) requiring participation from the following: state agencies, consumer advocates representing low-income recipients, consumer advocates representing people with disabilities, hospitals, managed care organizations (MCO), primary care providers (PCP), parents of children who are recipients, rural providers, advocates for CSHCN, pediatric providers, including specialties providers, long-term care provider, OB/GYN providers, community-based organizations (CBOs) serving low-income kids and families, CBOs engaged in prenatal services and outreach consumers, advocates, and providers to advise the state on Medicaid managed care on a statewide basis. The SMCAC meets quarterly and formed a CSHCN subcommittee to review issues pertaining to this subpopulation. A STAR+PLUS report is provided at each SMCAC meeting.

! Definition of Children with Special Needs

The State has a definition of children with special needs that includes at least five subsets:

1. Blind/Disabled Children and Related Populations (eligible for SSI under Title

XVI);

2. Eligible under Section 1902(e)(3) of the Social Security Act;
3. In foster care or other out-of-home placement;
4. Receiving foster care or adoption assistance; or
5. ***Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as is defined by the State in terms of either program participant or special health care needs.***

As discussed below, of these five subsets of CSHCN listed above, one is mandated to participate in managed care. However, that subset of children is not mandated into a capitated MCO; they may voluntarily choose a capitated model or they may choose the PCCM model, both STAR+PLUS health plans operated by MCOs. Additionally, children on SSI who do not make an elective choice, are auto-assigned to the PCCM model, not the capitated MCO model. See the discussion under #1 below. The following section describes each subset in relation to managed care.

1. Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI)
Blind/disabled children and related populations who are not eligible for Medicare must participate in one of the two STAR+PLUS service delivery models: the capitated model or the PCCM model. Children with special health care needs who receive SSI are given a choice between the two models, capitated or PCCM model in STAR+PLUS. In instances when no enrollment choice is made, by the parent, family member or guardian, within the designated timeframe, a mechanism for auto-assignment for children on SSI in STAR+PLUS ensures that children are assigned to the PCCM, not the capitated model. Thus, children in this subset are not mandated into a capitated model in STAR+PLUS. They would have to affirmatively elect/prefer the capitated model in STAR+PLUS. Both models are operated by MCOs contracted with the State. The number of children in STAR+PLUS as of June, 2002 totals 10,310. The number of children served in the PCCM model for June 2002 is 7,466, with 1,423 children served by one capitated MCO and 1,421 children served by the other.

2. Eligible under section 1902(e)(3) of the Social Security Act. **Texas does not include this optional Medicaid category in its State Plan.**

3. In foster care or other out-of-home placement **(addressed below under #4).**

4. Receiving foster care or adoption assistance.
Children in foster care or other out-of-home placement and children receiving foster care or adoption assistance are not eligible for the

Medicaid managed care program. To the extent that the children in these two categories are in managed care before transitioning, they may be included in the definition. The State has, therefore, developed coordination policies to address the needs of these children as they transition out of managed care. The state assures that the transition from managed care to fee-for-service is smooth for children moving in and out of State custody. The State has also developed policies to ensure appropriate health care for Medicaid children who are not in foster care but who are receiving services from the Texas Department of Protective and Regulatory Services (TDPRS). This is assured through contract provisions.

A section of the State's contract with MCOs addresses coordination issues for foster children during the transition from Medicaid managed care to fee-for-service. The MCOs must cooperate and coordinate with the Texas Department of Protective and Regulatory Services (TDPRS) for the health and behavioral health services of a child who is receiving services from or has been placed in the conservatorship of TDPRS. The MCOs cannot deny, reduce, or controvert the medical necessity of any health or behavioral health services included in an Order entered by a court. Any modification or termination of ordered services must be presented and approved by the court with jurisdiction over the matter for decision. MCOs are also required to schedule medical and behavioral health appointments within 14 days unless requested earlier by TDPRS. If the child is out of the geographic area, the MCO must provide services out-of-network as appropriate. An MCO must continue to provide all covered services to a member receiving services from or in the custody of TDPRS until the Member has been disenrolled from the MCO. Training on these provisions with MCOs and local TDPRS staff throughout the state has taken place, and the state provides ongoing information and training to the MCOs on how to handle these instances. The state also has an inter-agency workgroup (the TDPRS Regional Medicaid Managed Care Liaison Workgroup) comprised of representatives from the HHSC's Customer Services and Policy areas and the Department of Protective and Regulatory Services, Case Worker and Policy areas. This group meets regularly to discuss issues and concerns from a regional perspective.

In addition to these requirements, HHSC has established a workgroup with TDPRS to address issues related to foster care, out of home, and adoption assistance. MCOs receive training related to foster care issues, and these issues are also addressed through a HHSC/MCOprovider/member workgroup.

Texas has had a special focus on integrating Medicaid and TDPRS services for foster children through a grant the State Medicaid Office/HHSC

received. Texas was one of six states that received a technical assistance grant through the Nathan Cummings Foundation. The grant is part of an initiative to improve the health of children; the specific grant objective was to facilitate a collaborative relationship between agencies which usually have very limited contact with each other (e.g., Medicaid and Child Protective Services). The states in the grant (Alaska, Massachusetts, New Mexico, Utah, California and Texas) agreed to focus on interagency efforts to improve the health care of children in state custody (foster care). The grant provided state Medicaid, health and child protective agencies with the opportunity to learn from their colleagues in other states and to share their progress. Although no dollars were provided to the states, we have benefited greatly from what we have learned and have used that knowledge to improve working relationships and policies.

In Texas, we have focused our grant improvement efforts on the Medicaid system and its relationship to foster children and other children at risk for foster care placement (family preservation cases). Activities have included improving collaboration and communication between the Medicaid managed care system and TDPRS, staff, providers and members. This grant also helped the state understand and develop increased competency related to foster care issues in the transitioning of recipients out of managed care.

5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501 (a)(1)(D) of Title V, as is defined by the State in terms of either program participant or special health care needs.

In some states, Medicaid and Title V programs overlap in terms of eligibility and services offered. This eligibility overlap facilitates identification of CSHCN within Medicaid. That is not the case in Texas where the two programs are separate and distinct.

Texas' Title V program includes both a direct service program and population based activities such as health education. The direct service Title V program is called the Children with Special Health Care Needs Program or CSHCN, (Not to be confused with references in this document when the term 'children with special health care needs' is used). CSHCN eligibility criteria were developed (in part) to complement rather than duplicate Medicaid eligibility in Texas. CSHCN has, for example, higher income ceilings for eligibility. Therefore, for the most part, individuals who are eligible for Medicaid are not eligible for CSHCN. CSHCN will provide Title V services to Medicaid eligible children in only a very small percent of cases, when children require coverage of two services not provided under Medicaid: transportation of remains and certain specialty seating services.

With this small exception of families needing these two services, CSHCN children are not in Medicaid, and therefore not in Medicaid managed care.

Title V's population based activities and initiatives target a broader range of children that may include Medicaid children. These activities include health education, research, community support, and grants to organizations such as "Any Baby Can"and "Family to Family" which provide support services to CSHCN and their families. As part of its population based activities, Title V staff are also actively involved in supporting Medicaid managed care Regional Advisory Committees and the Department of Health's CSHCN Advisory Committee, as well as providing technical support to the Medicaid Fee for Service and Managed Care programs and to the state's CHIP program.

In Texas, the State has established managed care standards for those CSHCN who do choose to join an MCO. CSHCN are included in the broader age-neutral definition currently used by the state in its contracts with MCOs. The State's STAR+PLUS contract contains specific requirements addressing the needs of "People with Disabilities or Chronic or Complex Conditions" (PDCCC). A disability is defined in the contract as a physical or mental impairment that substantially limits one or more of the major life activities of an individual. A chronic or complex condition is defined in the contract as a physical, behavioral health, or developmental condition which may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated. We believe that the criteria outlined in the definition of PDCCC incorporate the SSI children who choose to join the STAR+PLUS capitated MCO.

- Identification

  The State identifies and/or requires MCOs/PHPs to identify children with special needs. The State collects, or requires MCOs/PHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above.

  The State identifies children with special health care needs through their XVI eligibility category. SSI children in Medicaid managed care are identified by the state and the managed care plans through their Medicaid eligibility category. The State's Enrollment Broker receives the Medicaid eligibility categories from the Texas Department of Human Services and then passes the information on to each managed care organization MCO along with the recipient's enrollment selections and/or assignment of MCO and Primary Care Provider (PCP). Similarly, children who, while in managed care, are transferred to foster care are identified within Medicaid

when their eligibility category changes from an existing eligibility category, e.g., TANF, or Federal Mandate, to a Foster Care category. MCOs are notified of this change and, as discussed above, requirements for the transitional services for these children address their needs as they transition out of Medicaid managed care when their status changes.

Monitoring of the appropriate identification of CSHCN through their eligibility categories is monitored by the state's ongoing quality assurance mechanisms for eligibility determination.

! Enrollment/Disenrollment

The State performs functions in the enrollment/disenrollment process for children with special needs, including: Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program.

The State's Enrollment Broker, MAXIMUS, Inc., is responsible for performing all functions of the enrollment process of all Medicaid managed care eligibles, including children with special needs. Disenrollment functions are performed by the Enrollment Broker under the supervision of the State. MAXIMUS is responsible for disenrolling recipients from one MCO to another. If a recipient, including those with special needs, wishes to disenroll completely from the STAR +PLUS Program, then the TDHS is responsible for reviewing and approving such requests for disenrollment.

MAXIMUS works very closely with the community to reach the special needs population. Agreements and subcontracts are made with the Community Based Organizations (CBOs) to assist the Enrollment Broker in education and enrolling recipients. In each service area, the Enrollment Broker participates in community groups, coalitions and committees that work directly with the special needs population, as well as broadcasting outreach efforts/activities at the RAC meetings.

MAXIMUS' regional offices have outreach workers housed in facilities such as DHS and other local organizations and agencies to provide education and outreach through enrollment events and other activities such as group presentations, one-on-one counseling (face-to-face in the region), enrollment events, and health fairs.

The State's Enrollment Broker networks with various entities in each service area that focus on children with special health care needs. In each service area, the Enrollment Broker is a member of the Regional Advisory Committee and serves on the Subcommittee for Children with Special Health Care Needs in the service areas that have a separate subcommittee

for CSHCN. In addition to MAXIMUS, the subcommittee is comprised of providers, advocates, and other state agency officials who meet on a quarterly basis to address specific issues and needs of the special needs population. MAXIMUS also works closely with the community groups and organizations in each service area that focus their attention on CSHCN.

MAXIMUS also sought direction/recommendations from representatives from the state's protection and advocacy organization, Advocacy, Inc., on who and how to contact other advocacy groups that target the special needs population.

> *Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCOs/PHPs and providers based on their medical needs.*

The Enrollment Broker developss creative strategies for reaching all eligible recipients, including children with special health care needs. Home visits are available as needed or upon request for recipients with special needs. The enrollment counselor tailors the education and enrollment to these recipients in the manner most appropriate in order to effectively communicate the available choices to the recipient, their parent and/or guardian.

The Enrollment Broker conducts training on a continuing basis through updates to community resources and changes to existing policies and procedures for all recipients.

The Enrollment Broker focuses on hiring experienced staff with specific backgrounds in working with the special needs population to enhance outreach and educational efforts through the diversity and added perspective that these individuals bring to the team. Enrollment counselors (field and telephone) receive training on mental health, substance abuse and other special needs issues and barriers in order to better assist and help support the special needs population in their selection of an appropriate MCO and PCP choice. The Enrollment Broker also has specialized units that are designated to focus on education, enrollment and individualized issues related to specific service areas where there are managed care programs specifically targeted to the special needs population. Although these units focus on their specific service areas, such as STAR+PLUS in Houston, they often share their expertise when they assist other enrollment counselors and/or members in all service areas with education and enrollment on occasion.

Auto-assignment process assigns children with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs.

TDHS requires MCOs, through contract provisions, to ensure that all of their members receive the care that they need, regardless of whether the provider of that service is in the MCO's network. If MCOs are unable to provide the needed care through their established networks, they must provide for the necessary services through out-of-network providers. The MCO is required to reimburse out-of-network providers for necessary services required by plan members. These requirements are intended to ensure that MCOs meet the needs of members, including CSHCN.

As noted in a previous section, the TDHS' auto-assignment process for children with special health care needs, ensures that no child becomes a member of a capitated MCO delivered model without an affirmative election. If children are auto assigned to the PCCM model, they may, at any time, change to the MCO capitated model by contacting Maximus, the Enrollment Broker.

A child with special needs can disenroll and re-enroll in another MCO for good cause.

The STAR + PLUS Program allows all recipients, including children with special needs, to disenroll and re-enroll in one of the capitated MCOs at any time. Children may change between the capitated model and the PCCM model at any time. All recipients have the right to change primary care providers up to four times per year without cause and with good cause thereafter.

If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way--including adverse change in an enrollee's health status an non-compliant behavior for individuals with mental health and substance abuse diagnosis--against the enrollee.

The MCO may submit a written request to the State to disenroll or transfer an enrollee to another plan. However, requests for reassignment for any member cannot be based on a change in the member's health status, for non-compliant behavior for individuals with mental health and substance abuse diagnosis or on the member's race, ethnic background, age, or gender. All reasonable measures to correct any problems must have been exhausted by the MCO prior to the request. The request must also include supporting documentation for review by the State. In addition, the MCO

must inform the member in writing of such a request, along with information about the MCO's complaint process and the State's Fair Hearing process. The final decision to disenroll a member from a managed care plan rests solely with the State.

Monitoring for enrollment and disenrollment is achieved through review of policies and procedures, as well as Enrollment Broker reports.

! Provider Capacity

The State ensures that the MCOs/PHPs in a geographic area have sufficient experience providers to serve the enrolled children with special needs (e.g., providers experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.).

Once identified, the MCO must have effective health delivery systems to provide the covered services to meet the special preventive, primary acute, and specialty health care needs appropriate for treatment of the individual's condition. Further, the MCO is required by the State to develop a plan of care to meet the needs of the member which may include allowing the member to utilize a specialist as the PCP. The MCO must provide all covered services as required by the Medicaid program.

MCOs were required to seek contracts with any Significant Traditional Providers (STPs) who have been serving the Medicaid population in the service area. STPs are defined by the State to include all hospitals in a service area that received disproportionate share hospital (DSH) funds and providers who have seen a significant number of Medicaid recipients during the state fiscal year prior to the implementation of Medicaid managed care. STP providers in STAR+PLUS had previously served a significant number of recipients in Harris county for the state fiscal year prior to implementation. The MCO gave STPs the opportunity to participate in their networks for at least three years from the date of implementation of STAR+PLUS if the provider: 1) agreed to accept the standard provider reimbursement rate of the MCO for the provider type; and 2) met the standard credentialing requirements of the MCO. Even though the three year time frame has passed for the STP protections in STAR+PLUS, the State continues to encourage MCOs to contract with significant traditional providers.

The Texas Department of Human Services (TDHS) reviews capacity during the initial review and continuously monitors capacity to determine that the MCO has providers who have experience working with persons with disabilities or chronic and complex conditions, such as HIV/AIDS.

Providers of long term care services in STAR+PLUS have demonstrated years of experience working with individuals with disabilities since these long-term care services providers operated in the fee for service system prior to STAR +PLUS. This factor was one critical attribute considered in the design of and selection of the STAR+PLUS site. TDHS requires the MCO, through contract provisions, to provide for any service needed by a member regardless of whether the MCO has providers in their network. The MCO must take special care to ensure the continuity of care of members whose physical health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if care is disrupted. The MCO is required to reimburse out-of-network providers a Medicaid fee-for-service amount or a "reasonable and customary"/negotiated amount.

MCOs must submit a monthly report summarizing changes in their provider network. The Provider Network Change Report must identify provider additions and deletions and the impact to the following:

(1) geographic access for the Members;
(2) cultural and linguistic services;
(3) the ethnic composition of providers;
(4) the number of Members assigned to PCPs;
(5) the change in the ratio of providers with pediatric experience to the number of Members under age 21; and
(6) number of specialists serving as PCPs.

The state monitors this report to assure that adequate capacity is maintained. The State also requires MCOs to submit a Provider Termination Report that identifies providers who cease to participate in MCO's provider network. The information must include the provider's name, Medicaid number, the reason for the provider's termination, and number of members served by the provider.

Another required report is the Provider Network Change Report. MCO/ must submit electronically to the Enrollment Broker a weekly report that shows changes to the PCP network and PCP capacity.

The State monitors experienced providers capacity.

The Texas Department of Human Services (TDHS) requires that MCOs identify the capacity for each PCP within their networks. The enrollment broker then provides a monthly report of any providers who reach 1,200 members so that additional monitoring for quality and access issues can be done if needed. The State also monitors these issues through satisfaction survey results and internal and external

complaint reports. Historically, there have been no problems with providers exceeding capacity. Through review of the Provider Network Change and Provider Termination reports the State can determine if any patterns or trends are or have developed that would negatively impact the disabled or chronic or complex population.

! Specialists
The State has set capacity standards for specialists.

The State has several methods for setting capacity standards for specialists. The State requires significant traditional providers who are specialists must be given an opportunity to be in the capitated MCO network. The MCOs are contractually required to maintain an adequate network of specialty providers, including pediatric specialty providers, to meet the needs of all members. The MCO must ensure that no member is required to travel in excess of 75 miles to secure initial contact with referral specialist; special hospitals, psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians, dentists or providers

The State monitors access to specialists.

The State monitors the availability of specialists in the MCO's network, during the readiness review, by requiring the MCO to submit a list of all specialists, identifying any special experience or practice limitations of each specialist, for review by the State. The State determines if there are sufficient numbers of all specialty types identified in the MCO's network and if not, requires the MCOs to submit a statement and plan describing how it will assure that all specialty care needed by its members will be provided. Additionally, during readiness review, the State reviews geo-access maps submitted by the MCO showing the location of all specialists, in relation to the 75-mile standard for geographic access, and in relation to the location of recipients by zip code.

The state requires that MCOs provide an electronic file summarizing changes in MCOs provider network to the Enrollment Broker. The MCOs will report on a monthly basis a list of all specialists in their network with specialty identification so that the Enrollment Broker will provide HHSC with the numbers of specialists in the MCO network on a monthly basis, which will provide more up-to-date information with which HHSC and TDHS can evaluate the impact of specialist capacity and capability to serve the children population. TDHS also receives these reports to evaluate the network capacity for long term care services for children. Additionally,

TDHS monitors the MCO quarterly complaint reports to identify problems and trends in the provision of service, particularly related to referrals for specialty care.

As discussed in the Quality section below, the state is in a process of negotiating with the EQRO to incorporate research and recommendations related to quality of care for CSHCN in our EQRO's next contract period. While not finalized, the tools being considered assess access to specialists and referrals (i.e., New England SERVE/Family Voices provider, family, and managed care surveys).

The State has provisions in MCO'/PHP' contracts which allow children with special needs who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access to specialists for the needed care.

The contract between the State and the MCOs states that the PCP for a member with disabilities or chronic or complex conditions may be a specialist who agrees to provide PCP services to the member. The specialty provider must agree to perform all PCP duties required in the contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request for a specialist to serve as a PCP for a member with disabilities or chronic or complex conditions. STAR+PLUS members in the capitated MCO may self-refer to a behavioral health specialist.

The State requires particular specialists types to be included in the MCO network. If specialists types are not involved in the MCO/PHP network, arrangements are made for enrollees to access these services (for waiver covered services only).

The MCOs must ensure availability and accessibility to appropriate specialists. Contractually, MCOs must maintain specialty providers, including pediatric specialty providers, within the network in sufficient numbers and areas of practice to meet the needs of all members requiring specialty care or services.

The state reviewed the MCO provider panel (including specialists) during the RFA process and readiness review to determine if the MCO can provide service either through contracts with specialists in the services area or through arrangements to provide specialty providers out-of-network. The MCO's provider panel is reviewed to ensure the panel includes the

following specialists: pediatric subspecialists (e.g., pediatric cardiologists, pediatric nephrologists, pediatric oncologists), vision providers (e.g., ophthalmologists, optometrists, eyewear vendors), dermatologists, cardiologists, neurologists, endocrinologists, radiologists/x-ray facilities (outside of the hospital), hearing providers (e.g., audiologists, hearing aid fitters/dispensers), podiatrists, laboratories (outside of hospital), anesthesiologists, gastroenterologists, home health agencies, renal dialysis services, physical therapists, speech/language pathologists, nephrologists, plastic surgeons, pathologists, urologists, ambulance services, DME vendors, long-term care providers, occupational therapists, allergists/ENT, orthopedic surgeons, respiratory therapists, infectious disease specialists, and licensed master social workers. If the MCO does not have these specialty providers, they receive a deficiency that requires the MCO to provide a corrective action plan prior to implementation or contract renewal. The corrective action plan must ensure that the MCO will actively recruit and contract with the specialist for its provider panel.

The MCO must include all medically necessary specialty services through its network specialists, subspecialists and specialty care facilities (e.g., children's hospitals, and tertiary care hospitals). The MCO must have appropriate multidisciplinary teams for people with disabilities or chronic or complex medical conditions. These teams must include the PCP, the member, and any individuals or providers involved in the day-to-day or ongoing care of the member. The MCO must include in its provider network the following entities or entities with an equivalent level of expertise: TDH-designated perinatal care facility, federally qualified hemophilia centers, state recognized trauma centers, and Medicaid approved pediatric transplant centers.

Additionally, each MCO is required to contract with each specialized pediatric laboratory in service areas, including laboratories located in children's hospitals.

Also, during the MCO review periods, HHSC reviews the MCOs policies and procedures relating to the provision of out-of-network services, requiring that MCOs have policies in place to arrange for and provide out-of-network services with the same effectiveness and speed with which specialty referrals can be made within the MCOs networks. In addition, HHSC also requires that the MCOs policy on payment of out-of-network providers meets the same time frames and efficiencies required as the payment of in-network providers.

No member is required to travel in excess of 75 miles to secure initial contact with referral specialists; special hospitals, psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians, dentists, or providers. The MCO must have appropriate multidisciplinary teams for services to the PDCCC population. These teams must include the PCP and any individuals or providers involved in the day-to-day or ongoing care of the member. The MCO must have care coordinators in STAR+PLUS who work with the member, family members, PCP and other providers to develop a plan of services and coordinate all services. Care coordination services are discussed in the next section.

! Coordination

The State requires an assessment of each child's needs and implementation of a treatment plan based on that assessment.

As discussed above capitated MCOs in STAR+PLUS have a unique service called "care coordination". STAR+PLUS children with special health care needs and other STAR+PLUS members, with chronic and complex conditions receive care coordination. Each capitated MCO hires and trains "pediatric care coordinators" to work exclusively with children. The capitated MCOs complete an initial assessment on new members in order to began needed services immediately. Following that, the care coordinator arranges for a more comprehensive assessment during the first 30 days. That assessment includes nurses, social workers and other professionals as needed to identify the child's needs with input from family members and care givers.
When this assessment is complete, an Individual Service Plan (ISP) is developed by the team, coordinated by the care coordinator.

Care coordination services, provided through care coordinators, link members with special needs and conditions to covered and non covered services. Care coordinators receive training in order to identify and know about all services available to members. There is a high expectation that they be knowledgeable of non covered services that are available in the Houston community in order to secure such when needed by the member. It is customary for the care coordinator, as part of his/her role in the assessment of member needs and service plan development, to connect members to services provided by local organizations, such as food banks, and other local charity providers. For children with special needs, care coordinators work with local school districts to make sure that the school and MCO collaborate on providing needed services to meet the child's needs. Care coordinators often attend the school-sponsored Admission

Review Dismissal (ARD) meetings, where the needs and progress of children with special needs in school is discussed. As children with disabilities 'age-out' of school services, care coordinators are involved in referring families to the adult vocational agency, the Texas Rehabilitation Commission (TRC) in order to begin transition services. Care coordinators also work with DHS regional staff in addressing a myriad of issues that could come up, such as Medicaid eligibility issues, transfers out of the STAR+PLUS service area, etc.

Care coordination services and the role care coordinator plays in arranging for the assessment of need and provision of STAR+PLUS services is monitored by the State and the EQRO's monitoring activities as reported in Section C of this renewal. (Note: The STAR+PLUS video, an attachment to this renewal, provides a good overview of care coordinator for members with special needs in STAR+PLUS).

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The State has required the MCOs/PHPs to provide case management services to children with special needs.

See the previous section for a discussion of care coordination services for STAR+PLUS members. The State defines care coordination services to include the traditional case management services that are expected at the member level. Additionally, MCOs must coordinate and collaborate with other programs that provide case management services to STAR+PLUS children enrolled in them. Plans are provided training on the various state programs available, including:

- **THSteps (EPDST) Medical Case Management Services,**
- **THSteps dental,**
- **Early Childhood Intervention (ECI) case management/service coordination,**
- **MHMR Targeted Case Management,**
- **Mental Retardation Diagnostic Assessment (MRDA),**
- **Mental Health Rehabilitation,**
- **Pregnant Women and Infant Case Management (PWI),**
- **Texas School Health and Related Services (SHARS),**
- **Texas Commission for the Blind (TCB),**
- **Title V case management,**
- **Tuberculosis (TB) services provided by TDH-approved providers,**

Medical Transportation Program,
- **Community Resource Coordination Groups (CRCGs), and**
- **Vendor Drugs.**

> ***These requirements are currently monitored through review of RFA response materials, review of member information and educational materials, through readiness review assessment of the plan's approach to PDCCC, and through complaint review. Monitoring of compliance is also achieved through member and provider surveys.***
>
> *The State has developed and implemented a process to collaborate and coordinate with agencies and advocates that serve special needs children and their families.*

The primary process and site for collaboration and coordination between agencies, providers and consumer advocacy organizations working with children with special needs, is the RAC subcommittee designated specifically for Children with Special Health Care Needs. That subcommittee works closely with the state's Title V program at the Texas Department of Health to improve services for CSHCN. As stated earlier, the chairman for the subcommittee is the Title V Regional Program Director for TDH. Title V staff have historically been involved in RFA and contract review for Medicaid managed care. The HHSC special health care needs policy analyst has participated on a CSHCN panel at the HRSA/MCHB Tri-Regional Meeting on CSHCN in Medicaid managed care, and as a member of the Texas Team at the first HRSA/MCHB Tri-Regional meeting. These relationships help improve collaboration and coordination between Medicaid managed care, the Title V program, and the local Title V contractors throughout the state.

In addition to these dynamics, the state has structural processes in existence to promote coordination and collaboration. For example, Title V CSHCN division staff participates in the Medicaid medical policy development groups. MCOs must coordinate care and establish linkages, as appropriate for a particular member, with existing community-based entities and services, including but not limited to:

- **Texas Department of Mental Health Mental Retardation (MHMR),**
- **Texas Commission on Alcohol and Drug Abuse (TACDA),**
- **Maternal and Child Health, Chronically ILL and Disabled Children's Services (CIDC), Medically Dependent Children Program (MDCP),**
- **Community Resource Coordination Groups (CRCGs),**
- **Interagency Council on Early Childhood Intervention (ECI),**

- **Home and Community-based Services and (HCS and HCS-O),**
- **Community Living Assistance and Support Services (CLASS),**
- **In Home Family Support,**
- **Primary Home Care, Day Activity and Health Services (DAHS),**
- **Deaf/Blind Multiple Disabled waiver program,**
- **Community Management Teams for the Texas children's Mental Health Plan (CMTs), and**
- **the Medical Transportation Program.**

The MCO is required, by contract, to coordinate with and make a good faith effort to obtain MOUs from community resources and community based organizations that serve persons with disabilities and chronic and complex conditions.

These requirements are currently monitored through review of RFA response materials, review of member information and educational materials, through readiness review assessment of the plan's approach to PDCCC, and through complaint review. In part, due to the state's CSHCN policy focus, readiness reviews have had a particular focus related to PDCCC and CSHCN. Monitoring of compliance is also achieved through member and provider surveys.

> *The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources.*

The HHSC CSHCN policy lead reports regularly to the TDH Title V CSHCN Advisory group on the status of the CSHCN in Medicaid managed care.

HHSC and Title V, have developed a process to share information on CSHCN issues that may come up in any of the SMCAC, RACs, or CSHCN subcommittee meetings.

The Behavioral Health subcommittee of the Harris County RAC is the primary forum for policy coordination for persons with mental illness or substance abuse needs. Staff from the STAR+PLUS MCOs and their behavioral health subcontractors, Local Mental Health Authorities, and Texas Commission on Alcohol and Drug Abuse are members of this subcommittee. The subcommittee meets quarterly and is convened by regional HHSC staff, along with staff from the Texas Department of Mental Health Mental Retardation.

The State also operates a core behavioral health group that includes staff from the Texas Departments of Health, Mental Health and Mental Retardation, Alcohol and Drug Abuse, and Human Services. As part of its work, this group also addresses behavioral health issues in managed care. Traditional providers of mental health/substance abuse services are represented on local advisory committees and groups. The State has also provided training on services provided by the Texas Commission on Alcohol and Drug Abuse (TCADA).

For HIV issues, STAR+PLUS MCOs must consult with TDH regional public health authority to ensure that members receiving clinical care of HIV are managed according to a protocol that has been approved by TDH. STAR+PLUS care coordinators coordinate with the TDH regional health authority to ensure that members with HIV receive risk reduction and partner elicitation/notification counseling. Community based organizations, providing services to persons with HIV, regularly attend the RAC meetings and communicate with RAC subcommittees when needed to better serve STAR+PLUS members who are HIV . Local and regional health authorities, especially in larger urban areas, may either receive Ryan White funds or have working relationships with Ryan White grantees.

PCPs may enter into contracts or agreements with traditional HIV service providers, which may include Ryan White grantees, in the service area to provide services such as case management, psychosocial support and other services. If the service provided is a covered service under the STAR+PLUS contract between the MCO and TDHS, the contract or agreement must include payment provisions.

The STAR+PLUS capitated MCOs must provide HIV services that include education, prevention, screening, counseling, diagnosis, and treatment. They are responsible for implementing procedures to ensure that members have prompt access to appropriate services for HIV.

Finally, because of State coordination between Medicaid and Title V, the State is in a good position to coordinate CSHCN efforts between Medicaid managed care, including STAR+PLUS, the Title V program and our new CHIP Phase II program. HHSC Medicaid staff, and Title V CSHCN have been involved in the development of the CHIP RFA and have been able to use our joint experience and understanding of the importance of CSHCN needs relating to coordination with state and community programs in the development of the CHIP Phase II program.

The State requires the MCO/PHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health

department, transportation, home and community based waiver, development disabilities, and Title V services.

The State requires the MCOs to enter into a Memorandum of Understanding (MOU) with TDH and the Local Mental Health Authority (LMHA) programs regarding the provision of services for essential public health services. These MOUs must delineate the roles and responsibilities of the MCO and the public health department for the following services: use of the TDH laboratory for THSteps newborn screens; lead testing; and hemoglobin/hematocrit tests; availability of immunizations through the Vaccines for Children Program; reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data; referral for Women, Infant, and Children Program (WIC); Pregnant, Women and Infant (PWI) Targeted Case Management; THSteps Outreach, Informing and Medical Case Management; participation in the community-based coalitions with the Medicaid-funded case management programs in MHMR, ECI, TCB, and TDH (PWI, CIDC, and THSteps Medical Case Management); referral to the TDH Medical Transportation Program; cooperation with activities required of public health authorities to conduct the annual population and community based needs assessments; and coordination and follow up of suspected or confirmed cases of childhood lead exposure.

Monitoring of MCO's efforts to enter into MOUs and/or establish linkages with other state agencies and community based organizations serving CSHCN is accomplished by reviewing MCO documentation, and discussing the MCO's actions and understanding of the need to coordinate with such organizations in order to properly serve their members.

! Quality of Care

Revised 9/13/2002

The State has some specific performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.).

MCOs are required to have effective health delivery systems to provide the covered services to meet the special preventive, primary acute, and specialty health care needs appropriate for treatment of the individual's condition. The guidelines and standards established by the American Academy of Pediatrics, the American College of Obstetrics/Gynecologists, the U.S. Public Health Services, and other medical and professional health organizations and association' practice guidelines whose standards are recognized by TDH must be used in determining the medically necessary services and plan of care for each individual. The MCOs are required to

educate providers on standards related to immunizations and well child checks and the EQRO has conducted CAHPS surveys in Harris county to evaluate using the CAHPS child Medicaid Managed Care survey. The STAR+PLUS subcommittee of the RAC on Children with Special Health Care Needs serves a vital role in identifying and best practices in serving this population.

The state continues to work with the EQRO to identify specific quality issues for CSHCN. Work components include:

- **Assistance in researching, developing and recommending what should comprise quality of care related to CSHCN in Medicaid managed care.**
- **Assistance in researching, developing and recommending quality monitoring strategies for care received by CSHCN. This includes recommendations relating to the use of the CAHPS CSHCN survey, the New England SERVE/Family Voices CSHCN surveys for families, providers and MCOs/PHP, and other approaches to assessing quality of care. This might include; for example, small targeted sample medical chart reviews within the context of an overall approach to quality assessment for CSHCN.**

The State's quality improvement section of this waiver renewal identifies a number of projects designed to improve services for all STAR+PLUS members. Although there are no specific improvement projects designated specifically for children with special health care needs, there are a number of ongoing forums and activities that result in continuous quality improvements in the services provided to each MCO's children. The RAC subcommittee on Children with Special Health Care Needs consistently recommends activities that improve services to children in STAR+PLUS. Through the efforts of this subcommittee problems and barriers to services have been identified (in some cases, anticipated before they occurred) and addressed in ways that have improved services for individuals as well as modifying systems within managed care. For example, the subcommittee identified barriers to smooth transitions between MCO services and Early Childhood Intervention (ECI) and public school services. The subcommittee convened informal meetings of appropriate staff and discussed the issues/problems in order to modify interagency practices to reach resolution. Additionally, each MCO designates special "pediatric care coordinators" who actively participant in the subcommittee's work. These pediatric care coordinators work with the families of children with special health care needs, acute and long term care providers in the MCO networks, other state agencies, and community based organizations, along with consumer and family support groups in Houston.

The State requires that the MCOs conduct pediatric asthma, ADHD, and well child focused studies. The focused studies assess services being provided, clinical indicators, and service within and across the service area. After analysis by HHSC and the state's EQRO the plans incorporate the results into their QIPs. The MCOs are then monitored by HHSC through deliverables and by EQRO through onsite visits.

! BBA Safeguards

To the extent appropriate, the State has adequately addressed Balanced Budget Act (BBA) guidance that HCFA has issued to date.

The State has addressed all Balanced Budget Act (BBA) guidance issued by CMS to date, relevant to the waiver.. The state continues to operate under 1915(b) waivers, and has not chosen to implement managed care through a State Plan Amendment. The state describes its program and how it meets federal law and CMS policy through its 1915(b) waiver applications, including submission of its contracts with MCOs providers..

In regard to BBA provisions related directly to Children with Special Health Care Needs, the state has followed CMS guidance that has been released. For instance, the December 17, 1997, letter to State Medicaid Directors outlines requirements for State Plan Amendments under Section 1932(a)(1)(A) of the Social Security Act. Although the state does not implement managed care through a State Plan Amendment, the state conforms to the December 17, 1997, guidance letter. The populations described in the letter are either excluded from the state's program or participate on a voluntary basis (i.e. SSI and SSI-related eligibles). STAR+PLUS recipients have the choice of at least two capitated MCOs and the PCCM model and are permitted to disenroll from the capitated MCO at any time for cause. Written materials provided to STAR+PLUS recipients must be on a fourth- to sixth-grade comprehension level and must be approved by the state prior to distribution.

The December 17 guidance also requires the state to have a methodology in place to ensure access to an adequate number of geographically accessible providers under the program and to identify the types of providers with which the state will have contracts. These are both described in the state's 1915(b) waiver applications and the former is expanded on elsewhere in this response. The state uses various means to ensure network adequacy and provider accessibility, including required submission by MCEs of provider capacity and related reports.

CMS also has issued guidance on special needs populations in the form of draft guidance titled "Key Approaches to the Use of Managed Care

Systems for Persons with Special Health Care Needs." This non-mandatory document describes key elements in designing a program that addresses the special needs among the recipient population. The manner in which the state addresses these elements, such as engaging key stakeholders in the planning and development of the program and related strategies, are described throughout this response to the Children with Special Health Care Needs criteria.

! Payment Methodology
The State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care.

Of the five subsets of CSHCN outlined at the beginning of this document, only SSI children may be enrolled in Medicaid managed care either by choice in the capitated MCO model or in the PCCM model. Although there are multiple capitation rates for STAR+PLUS members, there is no distinction in these rates for children. The methodology used is based on the fact that STAR+PLUS population would have high service needs requiring high utilization of long term care services. The rates used within the capitated MCO model are PMPM rates. The services for children in the PCCM model are reimbursed through fee for service.

! Plan Monitoring
The State has in place a process for monitoring children with special needs enrolled in MCOs/PHPs for access to services, quality of care, coordination of care, and enrollee satisfaction.

The State monitors MCO requirements related to access to services, quality of care, coordination of care and enrollee satisfaction in a variety of ways. The State monitors MCOs through member and provider satisfaction surveys and through the on-site and document review by its EQRO. Most recent EQRO studies have focused on care coordination services in STAR+PLUS, including qualitative interviews with members and care givers to discuss in depth factors relating to their own consumer satisfaction or lack of satisfaction.
Complaint analysis provides another method of performance monitoring. The MCOs are required by contract to submit quarterly reports of members and provider complaints which are monitored for trends effecting the provision of service, referrals to specialist, medical necessity, and appropriate care and treatment by the plan and providers. Additionally, the State captures and reviews Fair Hearing requests and overturns on appeal for patterns and trends. If patterns and trends of inappropriate medical necessity decisions are identified, corrective action will be implemented by

the MCO.

Plan requirements related to PDCCC and CSHCN are also monitored through review of materials, review of member information and educational materials. The Harris County RAC subcommittee on Children with Special Health Care Needs has assisted in reviewing and commenting on STAR+PLUS information and materials and is an invaluable source to assist the State and the MCOs in better serving children with special health.care needs.

Monitoring of compliance is also achieved through member and provider surveys. TDH also reviews the MCO's good faith effort to obtain MOUs and/or establish coordination linkages with community based organizations which serve PDCCC.

The EQRO monitors MCOs according to the guidelines and standards established by the American Academy of Pediatrics, the American College of Obstetrics/Gynecologists, the U.S. Public Health Service, and other medical and professional health organizations and association' practice guidelines whose standards are recognized by HHSC.TDH. Through its quality monitoring, the EQRO conducts on-site review of the MCOs to determine adequacy of access to service, quality of care, coordination of care and enrollee satisfaction. The EQRO also reviews records and documents related to the MCO's quality improve committee activities, resources, provider participation, and MCO monitoring, evaluation and oversight. It determines member satisfaction through the review of documents and records regarding member rights and responsibilities, benefits and services education, complaint process, and health services availability, accessibility, and adequacy.

It also reviews and monitors confidentiality of member information, age-specific care and services, access performance standards, member coordination of care, health information management, member health education, and provider-related processes. Specific criteria are monitored for disabled or chronic or complex members.

The State has standards or efforts in place regarding MCO'/PHP' compliance with ADA access requirements for enrollees with physical disabilities.

TDHS requires that all provider subcontractors be ADA compliant. The EQRO also addresses ADA requirements during their provider site visits. During readiness review, the State toured the MCOs local office facility to determine that ADA requirements are met concerning access to the MCO local facility. TDH captures information regarding

ADA complaints and consensus in its internal complaint tracking system. HHSC requires the MCOs to have lab and x-ray facilities located throughout the service area so that persons with disabilities, or chronic or complex conditions may receive lab and x-ray services at or near the provider's office without having to travel long distances to obtain such services. HHSC monitors the availability of lab and x-ray service providers throughout the service area on an as-needed basis through the complaint reports. HHSC also requires that MCOs allow physicians to draw lab samples and send them out for evaluation so that persons with disabilities, or chronic or complex conditions need not travel to receive lab services.

The State defines medical necessity for MCOs/PHPs and the State monitors the MCOs/PHPs to assure that it is applied by the MCOs/PHPs in their service authorizations.

The State defines medically necessary:

Medically necessary behavioral health services means those behavioral health services which:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder or to improve or to maintain or to prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service which can safely be provided; and

(e) could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered.

Medically necessary health care services means health care services, other than behavioral health services which are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a members health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the diagnoses of the conditions; and

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

The EQRO monitors MCOs to ensure that the MCOs provide all covered services to each eligible member. Additional monitoring activities ensure that the Member Handbook contains a description of all services provided by the MCO, an explanation of any limitations and exclusions from covered services, and HHSC's definition of medically necessary services for physical medicine, behavioral health and long term care services, information on how to obtain or access all covered services, and information, education and training programs to members, families, and Community-based organizations about the care and treatment available in the MCO's plan for members with disabilities or chronic or complex conditions.

Attachment F

STAR+PLUS Program Eligible Member Descriptions
(Category Codes, Type Programs and Base Plan Combinations)

CATEGORY TP BASEPLAN

CATEGORY 1- Aged

01 03	13
01 12	01
01 12	02
01 12	03
01 12	13
01 12	14
01 12	17
01 12	20
01 12	30
01 12	31
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01 13	01
01 13	02
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01 13	34
01 14	13
01 18	13
01 22	13
01 51	13

CATEGORY 3- Blind

03 03	13
03 12	01
03 12	02
03 12	03
03 12	13
03 12	14
03 12	17
03 12	20
03 12	30
03 12	31
03 12	32
03 12	33
03 12	34
03 13	01
03 13	02
03 13	03
03 13	10
03 13	13
03 13	14
03 13	17
03 13	20
03 13	30
03 13	31
03 13	32
03 13	33
03 13	34
03 14	13
03 18	13
03 22	13
03 51	13

CATEGORY 4- Disabled

04 03	13
04 12	01
04 12	02
04 12	03
04 12	13
04 12	14
04 12	17
04 12	20
04 12	30
04 12	31
04 12	32
04 12	33
04 12	34
04 13	01
04 13	02
04 13	03
04 13	10
04 13	13
04 13	14
04 13	17
04 13	20
04 13	30
04 13	31
04 13	32
04 13	33
04 13	34
04 14	13
04 18	13
04 22	13
04 19	13
04 51	13

Section G. Complaints, Grievances, and Fair Hearings

I. Definitions:

Previous Waiver Period

a. _ During the last waiver period, complaints and grievances operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. X Please provide definitions used by the State for complaint, grievance, or appeal.

Complaint means any dissatisfaction, expressed by a complainant orally or in writing to the HMO, with any aspect of HMO's operation, including, but not limited to, dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination, as that term in defined by Texas Insurance Code Article 20A.12, with the exception of the Independent Review Organization requirements; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a complainant. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member. The term also does not include a provider's or enrollee's oral/written dissatisfaction or disagreement with an adverse determination or a request for a Fair Hearing to the State.

b. _ Please describe any special processes that the State has for persons with special needs.

II. State Requirements and State Monitoring Activities:

Previous Waiver Period

a. _ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect

to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.

The State monitors complaints through review of complaint reports from the MCOs and the STARline, which is a tollfree hotline staffed by state employees who serve as client advocates. Most calls to STARline from clients involve either questions or complaints due to the client's misunderstanding or to systems issues, often relating to eligibility status. Many of the calls received by STARline involve issues unrelated to Medicaid managed care. Calls that do relate to STAR+PLUS are handled by a client advocate who can contact the MCO and work with the appropriate staff to resolve the client's issue. These calls are generally resolved informally to the client's satisfaction.

The State also monitors complaints and grievances through the EQRO's MCO onsite review, which includes a review of complaint and grievance policies and processes. In addition, the State monitors complaints and grievances through review of fair hearing logs. The chart below shows results of fair hearings during the previous waiver period (all appeals through August 2001):

	HHSC Acute Care	DHS Long Term Care
Sustained	35	73
Overturned	74	62
Dismissed	101	11
Withdrawn	184	45
Pending		
TOTAL	**394**	**191**

If review of any monitoring source indicates that an MCO is having a large number of complaints about the same issue, State staff contact the MCO and discuss the extent to which the MCO has already addressed any trend. If no action has been taken, the State requests that the MCO develop corrective actions to address the issue. A review of the next quarter's complaints focuses on the problem area from the previous quarter. For example, one MCO received a number of complaints from members having difficulty reaching an MCO representative by phone. The State discussed this issue with the MCO, and the MCO arranged for a new phone

system and implemented new phone procedures. Subsequent complaint reports reflected that the MCO effectively handled the problem.

c. Please mark any of the following that apply:

1. X A hotline was maintained which handles any type of inquiry, complaint, or problem.

2. X Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.

   The following chart summarizes complaints received by STARline and the MCOs during the previous waiver period The chart covers State Fiscal Year 2000 through Fiscal Year 2001. The State does not require a standard complaint format. These categories were chosen to be similar to the categories chosen by the Independent Assessor and how the complaints were reported in the waiver previously.

Complaint Type	STARline	MCOs	Total
Access	158	294	452
Quality	28	274	302
Administrative	42	328	370
Pharmacy	10	0	10
Misc	0	45	45
TOTAL	238	941	1179

3. X There is consumer involvement in the grievance process. Please describe.

   The grievance process is initiated by the client. The State requires the MCOs to provide assistance to clients wishing to access the complaint and grievance process. The State provides assistance to clients wishing to access the Fair Hearing process.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any State requirements and State monitoring activities in effect for MCO grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1. X The State requires MCOs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2. X The MCO grievance process is approved by the State prior to its implementation.

3. X An MCO enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process

   An enrollee can request a State Medicaid fair hearing at any time, for any reason. The State does not require requests to be in writing. State employees who receive a request forward the request to the fair hearings staff. MCOs must include in their notices to enrollees of an action information regarding the enrollee's right to immediately access the State process rather than go through the MCO's process. An MCO receiving a request from an enrollee must immediately submit the request to the State.

4. X Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

5. X The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

6. X Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of MCO enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed.

   Enrollees are informed of their rights at the time of MCO enrollment through the MCO's orientation activities and Member Handbook. The Member Handbook, which is prior approved by the State, contains information on enrollee rights regarding complaints, grievances and fair hearings. Enrollees are also informed of their rights if the MCO intends to take an action regarding the enrollee's services, by a letter the MCO sends that includes notice of the right to file a

complaint, grievance or fair hearing and the processes involved in doing so.

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1. X The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

   (a) X The MCO governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.

   (b) _ The governing body or its delegated grievance committee reviews and resolves complaints and grievances. If the State has any committee composition requirements please list.

   (c) X Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

   (d) X Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame.

   MCO grievance process –30 days
   Fair hearings – 90 days

   (e) X Includes time frames for resolution of grievances for MCO grievances. Specify the time frame set by the State.

   Client complaints or grievances must be resolved within 30 days of the MCO receiving the complaint or grievance.

   (f) X Establishes and maintains an expedited grievance review process for the following reasons. Specify the time frame set by the State for this process.

   The MCO must allow enrollees a grievance review within 48 hours if the complaint involves a quality of care or urgent medical issue.

   (g) X Permits enrollees to appear before MCO personnel

responsible for resolving the grievance.

(h) _ Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State within a time frame specified by the State. Specify the time frame.

(i) X The MCO acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs to acknowledge complaints and grievances, please specify:

The MCO is required to acknowledge receipt of each complaint and grievance within 5 days.

(j) X Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(k) X Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l) X If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

(m) X Bases the MCO's decision on the record of the case.

(n) X Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, a as the procedures available to challenge or appeal the decision.

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(o) _ Upon request, provides enrollees and potential enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(p) _ Sets time frames for the MCO to authorize or provide

a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame.

(q) X Informs the enrollee of any applicable mechanism for resolving the issue external to the MCOs own processes.

(r) _ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(s) _ Other (please explain):

2. X MCOs maintain a log of all complaints and grievances and their resolution.

3. X MCOs send the State a summary of complaints and grievances on at least an annual basis.

4. _ The State requires MCOs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

5. _ The State requires MCOs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6. X The State and/or MCO have ombudprograms to assist enrollees in the complaint, grievance, and fair hearing process.

7. _ Other (please specify):

Section H. Enrollee Information and Rights

I. Enrollee Information - Understandable to Enrollees:

Previous Waiver Period

a. _ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. The differences were:

b. X [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll. *See* **Attachment 11**, which includes current sample enrollment packets for STAR+PLUS including the brochure and informational materials.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or MCO. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. X [Required] The State will ensure that enrollee materials provided to enrollees by the State, the enrollment broker, and the MCO are clear and easily understandable.

b. X Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):
Spanish

The State has chosen these languages because (check any that apply):

1. _ The languages comprise all prevalent languages in the MCO service area.

2. X The languages comprise all languages in the MCO service area spoken by approximately 10 percent or more of the population.

3. _ Other (please explain):

c. X Program information is available and understandable to non-

English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

The Enrollment Broker and the MCOs voluntarily hire outreach staff that speak languages other than Spanish. In addition, the Enrollment Broker and MCOs contract with the AT&T language line to ensure that all enrollees can access the information they need in a language they can understand.

d. X [Required] Translation services are available to all enrollees, regardless of languages.

e. X Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments: *Yes*

f. X The State requires MCO marketing materials to be translated into alternative formats for those with visual impairments.

II. Enrollee Information - Content:

Previous Waiver Period

a. During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

1. X Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

The State requires that all new enrollees receive either a

telephone or face-to-face orientation from the MCO. The MCOs conduct home visits for orientation to clients who request it, but the State does not require that all new enrollees receive face-to-face orientation. In addition, the MCOs are required to send each new enrollee information about how to access the managed care system and their rights and responsibilities.

2. X An initial notification letter

3. X Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

4. X A form for enrollment in the waiver program and selection of a plan

5. X A list of plans serving the enrollee's geographical area

6. X Comparative information about plans

7. X Information on how to obtain counseling on choice of MCOs

8. X Detailed provider network listings

9. X A new Medicaid card which includes the plan's name and telephone number

10. X A health risk assessment form to identify conditions requiring immediate attention.

11. X Information concerning the availability of special services, expertise, and experience offered by MCOs and providers

12. X [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13. _ [Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)

14. X [Required for MCOs] Information on how to obtain services not covered by the MCO but covered under the State plan.

Although certain Texas Medicaid State Plan services are not

provided by the MCO, all STAR+PLUS health plans are required to provide appropriate referrals for members to access these services. The plans are also required to provide member education, which includes information on how to obtain all Medicaid benefits, including those outside the MCO's capitation like transportation and EPSDT dental services. The plan's member services and care coordination staff are responsible for helping members access other resources and services that are not provided by the plan, including Medicaid services not provided by the MCO as well as a broad range of services provided through other federal and state funding streams (ie, Title V, food stamps, etc.) and community-based social service agencies.

15. _ [Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs (See A.III.b.5)

16. _ Other items (please explain):

b. Information provided by the MCO The State requires the MCO to provide, written information on the following items to enrollees and potential enrollees. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO (the BBA requires some information be provided only upon request). Please check all that apply.

1. X [MCOs required to provide upon request] Enrollee rights.

2. X [MCOs required to provide upon request] Enrollee responsibilities.

3. X [MCOs required to provide upon request] Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

4. X [MCOs required to provide upon request] Amount, duration and scope of all benefits (included and excluded).

5. X [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.

6. X [Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.

7. X [MCOs and PHPs required to provide upon request *and* upon enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

8. X [Required for MCOs] Procedures for obtaining services, including authorization requirements.

9. X [Required for MCOs] After-hours and emergency coverage. The State ensures enrollee access to emergency services by requiring the MCO to provide the following information to all enrollees:

   i. X the right to use participating and non-participating providers

   ii. X definition of emergency services

   iii. X the prudent layperson definition of emergency medical condition

   iv. X the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)

   v. X the right to access emergency services without prior authorization

10. X [Required for MCOs] Procedures for obtaining non-c Revised 9/13/2002
or out-of-area services.

11. X [Required for MCOs] Any special conditions or charges that may apply to obtaining services.

12. X [Required for MCOs and PHPs] The right to obtain family planning services from any Medicaid-participating provider

13. X [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.

14. X [Required for MCOs] Charges to enrollees, if applicable.

15. X [Required for MCOs] Procedures for changing primary care providers.

16. X Procedures for obtaining mental health, substance abuse, and developmental disability services.

17. _ Procedures for recommending changes in policies or services.

18. X The covered service area.

19. X Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

20. _ A description of new technology for inclusion of a covered benefit.

21. _ Enrollees' right to obtain information about the MCO, including information standards, utilization control procedures and the financial condition of the organization.

22. _ Other (please describe):

III. Enrollee Rights:

Previous Waiver Period

a. _ During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs protect enrollee rights. The State requires MCOs to:

a. X Have written policies with respect to enrollee rights.

b. X Communicate policies to enrollees, staff and providers.

c. X Monitor and promote compliance with their policies by staff and providers.

d. X Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil rights and anti-discrimination laws.

e. X Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f. X Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g. X Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h. X Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i. X Ensure that each enrollee has the right to refuse care from specific providers.

j. X Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k. X Comply with requirements of Federal and State law with respect to advance directives.

l. X Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

m. X Allow direct access to specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

n. _ Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a. _ During the last waiver period, the monitoring compliance with enrollee information and rights operated differently than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint].

The State requires MCOs to submit all enrollee materials for prior approval. The State reviews all materials for accuracy and clarity, and to ensure that all required elements are included in the material. If the State finds that any of the information is misleading, unclear, or does not contain all the required elements, the MCO must make corrections and submit again for approval before using the materials. The State required corrections and resubmission of some enrollee materials during the previous waiver period.

The State also monitored enrollee complaints. The State discussed complaints with the MCOs and worked through resolutions to particular complaint topics when appropriate. However, no formal corrective actions were necessary during the waiver period relating to enrollee information and rights.

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a. _ The State tracks disenrollments and reasons for disenrollments or requires MCOs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b. X The State will approve enrollee information prior to its release by the MCO.

c. X The State will monitor MCO enrollee materials for compliance in the following manner (please describe):

The State requires MCOs to submit all information to be sent to

enrollees to the State for approval before the material may be used. The State reviews all materials for accuracy and clarity, and to ensure that all required elements are included in the material. If necessary, the State requires the MCO to make changes to the submitted materials before sending the material to enrollees.

d. X The State will monitor the MCOs compliance with the enrollee rights provisions in the following manner (please describe):

The State monitors MCO compliance with enrollee rights through review of quarterly client complaint reports, STARline calls and appeals. In addition, the State requires the MCOs to provide information regarding enrollee rights in the member handbooks that must be sent to each enrollee. The State monitors the information provided by the MCOs by reviewing all material for accuracy and clarity. If necessary, the State requires the MCOs to make changes to the submitted materials before sending the material to enrollees.